IN THE UNITED STATES COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION

MDL NO. 2804
Case no. 7-mdl-284
Judge Dan Aaron Polster

This document relates to:
The County of Summit, Ohio, et al., v. Purdue Pharma L.P., et al.,
Case No. 1:18-OP-45090 (N.D. Ohio)
Case No. 17-OP-45005
Case No. 18-OP-45090

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Videotaped deposition of
CHAD GARNER
November 14, 2018
8:35 a.m.

Taken at:
Sheraton Columbus Capital Square
75 East State Street
Columbus, Ohio

Wendy L. Klauss, RPR

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THE VIDEOGRAPHER: We are now on the record. The date is November 14, 2018. The time is 8:35 a.m. The caption of this case is In Re: National Prescription Opiate Litigation. The name of the witness is Chad Garner.

At this time the attorneys present and those attending remotely will identify themselves and the parties they represent.

MS. BROWNE: Maureen Browne, Covington & Burling, for McKesson.

MR. GLYNN: Vincent Glynn, Covington & Burling, for McKesson.

MR. KEYES: Andrew Keyes, Williams & Connolly, Cardinal Health.

Mr. BUSHUR: Joseph Bushur, Williams & Connolly, Cardinal Health.

MS. RANJAN: Brandy Ranjan, from Jones Day, on behalf of Walmart.

Mr. FARRELL: Paul Farrell, Jr., on behalf of the MDL plaintiffs.

MR. BREWER: Mat Brewer, from Bartlit Beck, on behalf of Walgreens.

MS. O'GORMAN: Debra O'Gorman, from Dechert LLP, on behalf of Purdue defendants.

MR. EMCH: Al Emch, Jackson Kelly, on behalf AmerisourceBergen Drug Corporation.

MS. PAYER: Charissa Payer, Ohio Attorney General's office, on behalf of the Ohio Board of Pharmacy.

MS. DEHNER: Nicole Dehner, Ohio Board of Pharmacy.

MR. WAKLEY: James Wakley, Senior Assistant Attorney General, on behalf of the Board of Pharmacy.

THE VIDEOGRAPHER: People on the phone.

MS. BYRNES: Rachel Byrnes, from Tucker Ellis, on behalf of Janssen and Johnson & Johnson.

MR. RUIZ: Anthony Ruiz, with Zuckerman Spaeder, on before of CVS Rx Services, Inc., and CVS Indiana LLC.

THE VIDEOGRAPHER: Will the court reporter please swear in the witness.

CHAD GARNER, of lawful age, called for examination, as provided by the Statute, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF CHAD GARNER

BY MS. BROWNE:

Q. Good morning, Mr. Garner. We met off the record. My name is Maureen Browne, and I'm with the law firm of Covington & Burling, and I represent the defendant McKesson in this litigation.

Would you please state your name for the record.

A. My name is Chad Garner.

Q. Are you currently employed, Mr. Garner?

A. Yes.

Q. And where is that?

A. The State of Ohio Board of Pharmacy.

Q. What is your role at the Ohio State Board of Pharmacy?

A. The director of the OARRS program.

Q. And what does OARRS stand for?

A. The Ohio Automated Rx Reporting System.

Q. How long have you been the director of the OARRS program?

A. About six years.

Q. Throughout this deposition, if we

refer to the Ohio -- or if we use the term OARRS, you will know what I'm speaking of, correct?

A. Yes.

Q. Prior to -- well, let me ask you this: Have you been deposed before?

A. No.

Q. So today I'll be asking you a series of questions for which I request that you give me an oral response. Wendy is taking down everything that is said in the room, so she cannot take down nods of the head --

A. Correct.

Q. -- is that understood?

A. Yes.

Q. I would also ask that, although you may be able to anticipate my question, you wait for me to finish it before you answer, and again, that's so we have a clean record; is that fair?

A. Sure.

Q. Is there any reason that you would be unable to give your full, complete, and honest testimony?

A. No.

Q. Are you under the influence of any medication or alcohol that may impair your ability to give testimony today?

A. No.

Q. If you do not understand a question that I ask, please let me know, and I'll rephrase it.

A. Okay.

Q. Also, Mr. Wakley may impose an objection from time to time to one of my questions. If he does, and he does not instruct you not to answer, please provide an answer to the question, okay?

A. Okay.

Q. We probably will take a break every hour, but if you need a break at any time, go ahead and ask for it, no problem. We will just complete whatever question may be pending at that time, and then we can take a break, understood?

A. Okay.

Q. Okay. What, if anything, did you do to prepare for today's deposition?

A. We had a couple of meetings to discuss what questions we thought might be

asked.

Q. And who is "we"?

A. Me and the attorneys here.

Q. So that's your attorney Mr. Wakley and then Ms. Dehner?

A. Yes.

Q. And then also Ms. Payer, was she there?

A. Ms. Payer was not there.

Q. Okay. Other than Mr. Wakley and Mr. Dehner, did you prepare with any other lawyers?

A. No.

Q. Did you have any conversations with any of the lawyers for the plaintiffs in this litigation?

A. No.

Q. Do you understand who the plaintiffs are in this litigation?

A. I believe so.

Q. What is your understanding?

A. My understanding is that it is the state and various counties.

Q. Have you met Mr. Farrell before today?

A. No.
Q. Other than meeting with your attorneys, did you review any documents to prepare for today?
A. I reviewed a subpoena.
Q. Anything else?
A. No.
Q. How long did you meet with your attorneys?
A. A couple hours.
Q. And when was that?
A. A couple weeks ago, as well as last week.
Q. Did you speak with anyone other than attorneys to prepare for the deposition today?
A. No.
Q. You didn't have any conversations with anyone else at the Ohio Board of Pharmacy in order to prepare for today?
A. No.
Q. When were you first told that you would be giving a deposition in this case?
A. Oh, I think it was probably a month, month and a half ago.

Q. And what specifically were you told about the deposition?

A. Very little. Just that there would be one.

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(Thereupon, Deposition Exhibit 1, Notice of Videotape 30(b)(6) Deposition of the State of Ohio Board of Pharmacy, was marked for purposes of identification.)

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Q. We are going to mark as Exhibit 1 the notice of videotape deposition. You can take a minute to look through Exhibit 1, if you would, Mr. Garner.

Have you had a chance to review Exhibit 1, Mr. Garner?

A. Yes.

Q. Have you seen Exhibit 1 before?

A. Yes. It was with the subpoena.

Q. And that's the subpoena for deposition that you understand has compelled your testimony here today?

A. Correct.

Q. Will you turn to page 5 of that

subpoena, please. I'm sorry. Page 7, I apologize.

Page 7 identifies topic 16, and it read, "The OARRS database, including why it was created, what purpose it serves, the data it contains, and the evolution of its capabilities utilization from 2006 to the present." Did I read that correctly?

A. Yes.

Q. Is it your understanding that you are here to testify about topic 16 of Exhibit 1?

A. Yes.

Q. Thank you. You can set that aside.

- - - - -

(Thereupon, Deposition Exhibit 2, Subpoena to Testify at a Deposition in a Civil Action, was marked for purposes of identification.)

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Q. I'm next going to hand you what has been marked as Exhibit 2. Exhibit 2 is the subpoena for you to testify in your individual capacity today; do you see that?

A. Yes.

Q. Have you seen Exhibit 2 before?
A. Yes.
Q. And do you understand that Exhibit 2 compels you to testify today in your individual capacity, in addition to the testimony you will give regarding topic 16?
A. Yes.
Q. You mentioned you have been the director of OARRS for six years; is that right?
A. Yes.
Q. Did you hold any positions with the board of pharmacy prior to becoming the director?
A. Yes.
Q. And what position was that?
A. Immediately prior to becoming the director, I was the chief information officer.
Q. Were you the chief information officer of OARRS prior to becoming the --
A. The board.
Q. Is your employer the board of pharmacy?
A. Yes.
Q. As chief information officer at the board of pharmacy, what were your duties?

A. My duties were to -- I was basically in charge of all technology, so anywhere from computer servers, phone systems.

Q. And as chief information officer at the board of pharmacy, in addition to overseeing the phones and the computers and IT systems, you were responsible for the operations of the OARRS database?

A. No. There was a different director of OARRS at that point.

Q. In your role as the chief information officer at the board of pharmacy, did you have any connection with the OARRS database?

A. The OARRS database was hosted on the servers that I -- that I ran.

Q. Did you have access to any of the data that resided on the OARRS database in your role as the chief information officer at the board of pharmacy?

A. Yes, I would have had access.

Q. Did you ever access the data on the OARRS database during your tenure as the chief information officer?

A. Not that I can recall.

Q. Prior to becoming the chief information officer at the Ohio Board of Pharmacy, did you have any other roles with the Ohio Board of Pharmacy?

A. Yes.

Q. What was that role?

A. I was the OARRS database administrator.

Q. And for how long did you hold that role?

A. Since late 2005.

Q. For how long a period were you the OARRS database administrator?

A. About four years.

Q. So until about 2009?

A. Yes.

Q. And it was in approximately 2009 that you became the chief information officer?

A. Yes.

Q. As the OARRS database administrator, what were your duties?

A. I was in charge of all technology specifically related to OARRS.

Q. And when you say you were -- as the OARRS database administrator, you were

responsible for all technology related to OARRS, what do you mean by that, what technology?

A. So the servers that OARRS ran on, the network that it ran on, any software, all of those would have been my responsibility.

Q. To whom did you report when you were the OARRS database administrator?

A. The director of OARRS.

Q. And to whom did you report when you were the chief information officer?

A. The executive director.

Q. The executive director of the board of pharmacy?

A. Yes.

Q. When you say that you were responsible for the servers that OARRS ran on, the network and the software, did you have responsibility for choosing, for example, any software updates?

A. Yes.

Q. And did you choose vendors?

A. Yes. At that point, I did.

Q. Did you choose the vendor who supplied the OARRS database?

A. No. That was -- that decision had been made before I started.

Q. Who made the decision as to the vendor to -- who would supply the OARRS database?

A. I don't know.

Q. What if any software changes did you implement while you were the OARRS database administrator?

A. So there are two sides of OARRS. There is the prescription side and the wholesale side. I wrote the wholesale side. It was not off-the-shelf software.

The prescription side, we made various changes to the software, in order to increase capacity.

Q. When you say that you wrote the code for the wholesale side of OARRS --

A. Yes.

Q. -- is the wholesale side -- well, tell me what the wholesale side is?

A. So all wholesalers licensed by the State of Ohio Board of Pharmacy are required to submit certain information about sales of controlled substances to the OARRS program.

The wholesale side of OARRS is the side that collects that information.

Q. Have you heard of McKesson before?

A. Yes.

Q. Do you know what McKesson does?

A. Yes.

Q. What is it?

A. They are a wholesaler of prescription drugs.

Q. Have you heard of AmerisourceBergen before?

A. Yes.

Q. Do you know what AmerisourceBergen does?

A. Yes.

Q. What is that?

A. They are a wholesaler of prescription drugs.

Q. Have you heard of Cardinal Health before?

A. Yes.

Q. Do you know what Cardinal Health does?

A. Yes.

Q. What is that?

A. They are also a wholesaler of prescription drugs.

Q. Do any of McKesson, ABDC -- let me ask you this. If I refer to AmerisourceBergen as ABDC, will you understand what I mean?

A. Yes.

Q. Thank you. Does any of McKesson, ABDC or Cardinal Health have access to the wholesale side of the OARRS database, to your knowledge?

A. Do you mean "access," as in can they get data from it?

Q. Well, let me ask. That's a good question.

Can they input data?

A. Yes.

Q. Can they get data from it?

A. No.

Q. Other than writing the code for the wholesale side of the OARRS database, you mentioned that you made changes to the software on the prescriber side to increase capacity, correct?

A. Yes.

Q. And increase capacity how?

A. In 2011, there were some changes to law that dramatically increased the usage of the system. The system at that point was not able to keep up with that type of usage, and so we had to make changes to the software in order to allow it to keep up.

Q. What if any input did you have in recommending any changes to the increased capacity on the prescriber side?

A. I had -- that was entirely me.

Q. That was entirely you?

A. Yes.

Q. When you say it was entirely you, what do you mean by that?

A. I made the decision to make the change, and I actually wrote the code to make the change.

Q. So you wrote the code to increase the capacity on the prescriber side of OARRS in 2011?

A. Yes.

Q. And you also wrote the code to create the wholesale side of the OARRS database?

A. Yes.

Q. And when was that?
A. 2006.
Q. By the time -- you mentioned to me that you were the OARRS database administrator from 2005 to 2009, correct?
A. Yes.
Q. But you wrote the code to increase capacity for the prescriber side in 2011?
A. My dates may be off by a bit, as far as when I was in each position. They kind of blur together a bit.
Q. But you are sure that you wrote the code to increase the capacity on the prescriber side, correct?
A. Yes.
Q. And you are sure that that was in 2011?
A. 2010, 2011, that's when the statute passed.
Q. What statute is that?
A. It was then referred to as House Bill 93.
Q. Do you know what it ended up being codified as?
A. It was in --

Q. The code section --
A. It was in a lot of code sections.
Q. Okay. So when you were the OARRS database administrator, we talked about the software updates, or a couple of the software updates.
Did you do any other software updates as the database administrator of OARRS, other than increasing the capacity of the software on the prescriber side and implementing the wholesale side of the database?
A. No. I mean, aside from just the routine updates that come out from various software vendors, no.
Q. So just the pushes, but --
A. Right, just patches and --
THE NOTARY: Wait a minute. You have to let her finish.
"So just the pushes, but" --
Q. -- but not any original code writing?
A. Correct.
Q. You said that you were also responsible for the network, when you were the

OARRS database administrator. What did you mean by that?

A. I chose the network hardware, I installed and configured the network hardware, maintained it.

Q. Is OARRS still running the same hardware as it did -- the same network hardware as it did when you were the database administrator?

A. No.

Q. What was the hardware that was running while you were the administrator?

A. There were -- there was a Cisco firewall, Cisco switches.

Q. Anything else?

A. Dell servers.

Q. Anything else on the hardware side, other than the firewall, the switches, and the Dell servers?

A. No.

Q. And you said that today the network is not the same as it was when you were the database administrator?

A. No, it is not.

Q. How many times has it changed,

since the time that you were the administrator?
A. Twice.
Q. What is it currently, the current hardware configuration?
A. It is currently hosted in the cloud.
Q. When did OARRS become cloud hosted?
A. April 2017.
Q. And prior to cloud hosting, where was -- what hardware supported the OARRS network?
A. It was similar hardware and software, just upgraded versions.
Q. When you say "similar," you mean similar to the Cisco and Dell combination?
A. Correct. It is still a Cisco and Dell combination, just updated hardware.
Q. You also said that as the network -- I beg your pardon -- the OARRS database administrator, you were responsible for the servers that OARRS ran on; do you recall that?
A. Yes.
Q. You mentioned that currently -- well, back up.

When you were the database administrator, where were the servers located?

A. At the board of pharmacy office.

Q. And where are the servers located today?

A. They have been split. The prescription side is hosted on Amazon cloud, the wholesale side is hosted -- it's still hosted at the board of pharmacy.

Q. And the server change took place -- well, did the server change take place at the same time the hardware change was implemented?

A. Did the server --

Q. Strike that. Let me ask you another question.

When did the prescriber side of the OARRS database migrate to the Amazon cloud?

A. That was April of 2017.

Q. But for the life of the wholesale side, that database, the servers have existed at the BOP, correct?

A. Yes.

Q. If I referred to the board of pharmacy as BOP, will you understand what I

mean?

A. Yes.

Q. Other than your responsibilities for the servers that the OARRS database ran on, the network and the software, in your role as the OARRS database administrator, did you have any other functionality or functions?

A. I don't believe so.

Q. Prior to your role as the OARRS database administrator at the board of pharmacy, did you have any other roles with the board of pharmacy?

A. No.

Q. Do you have an undergraduate degree?

A. Yes.

Q. In what?

A. Computer science.

Q. Do you have any graduate education?

A. Yes.

Q. What is that?

A. I have a Master's of Science in computer information systems.

Q. When did you get that?

A. The master's I received in 2017.

Q. From where?
A. Boston University.
Q. And did you go to Boston University to get that, or did you do that --
A. It was on line.
Q. And where is your CS degree from?
A. Mount Union Nazarene University.
Q. And when did you receive that?
A. 2004.
Q. Other than your roles at the board of pharmacy, have you worked anywhere else, since your graduation from college?
A. Yes.
Q. Where.
A. Optimum Technology?
Q. Was that right out of college?
A. Yes.
Q. 2004 to 2005?
A. Yes.
Q. And what did you do at Optimum Technology?
A. I was their network administrator and a customer support analyst.
Q. Let's talk a little bit about your current role as the director of OARRS.

A. Okay.

Q. What are your roles and responsibilities as the director of OARRS?

A. So I manage all aspects of OARRS, vendor relations, as well as managing the OARRS staff. I also do -- I also do reporting from OARRS.

Q. Anything else in your role as the director of OARRS that you do, other than vendor relations, staff management, and reporting from OARRS?

A. Public speaking, from time to time, attending various meetings, representing the agency at, you know, various meetings and gatherings.

Q. When you say, "Representing the agency at various meetings and gatherings," is that the board of pharmacy or is that OARRS?

A. Well, the agency would be the board of pharmacy, but I am there specifically for OARRS. If the meetings weren't OARRS related, I wouldn't be the person that was sent.

Q. Other than vendor relations, staff management, reporting from OARRS, some public speaking, attending meetings related to OARRS,

and representing the agency where -- on behalf of the BOP, where OARRS is specifically being addressed, are there any other roles and responsibilities that you undertake as the director of OARRS?

A. I would include in reporting, you know, there is a lot of data analysis, statistical types of analysis that goes with that.

Q. So in your role managing vendor relations as the director of OARRS, what do you do?

A. I have weekly meetings with the OARRS software vendor; I also, you know, for other various smaller pieces of software, may occasionally have a meeting or a phone call.

Q. Who is the OARRS software vendor?

A. Appriss.

Q. Can you spell that?

A. A-P-P-R-I-S-S.

Q. Is there one individual with whom you interface at Appriss?

A. There is one main point of contact, but there are a number of others that I may interface with, from time to time.

Q. Who is your main point of contact at Appriss?
A. Tonya Vaughn.
Q. Do you know how to spell her last name?
A. V-A-U-G-H-N.
Q. Is Appriss the only OARRS software vendor with whom you interface?
A. Appriss is the prescription monitoring program vendor. So that is the main -- that is the core OARRS software.
Q. Are you familiar with the term "PDMP"?
A. Yes.
Q. And what does that stand for?
A. Prescription drug monitoring program.
Q. If I use PDMP in this deposition from time to time, will you understand that I'm referring to a prescription drug monitoring program?
A. I will. If I say PMP though, I mean the same thing.
Q. Fair enough. You said that you occasionally will have meetings with or calls

with smaller software vendors in your role as the director of OARRS; is that right?

A. Yes.

Q. And can you identify any of those smaller software vendors for me?

A. It is possible we could have a conversation with Microsoft for something -- or most of our software is Microsoft, so that would be the most likely.

Q. What would be the nature -- can you call to mind a specific meeting or call that you have had with Microsoft in the past, in your role as the director of OARRS?

A. Not a specific one, no.

Q. Historically, what would be the nature of any call that you have had with Microsoft about OARRS?

A. It would be either a marketing call or something to do with any type of issue we are dealing with that we can't find resolution to on our own.

Q. When you say it could be a marketing call, what type of -- what do you mean by that?

A. They have a government relations

staff that call every once in a while to discuss new products that they have that they think might be beneficial to us.

Q. Have you ever followed up on one of those marketing calls to purchase a new product that Microsoft suggested might be beneficial?

A. I'm trying to remember if -- we did eventually upgrade a version of SQL server after a conversation with Microsoft, but I don't remember if it was a marketing call or if I happened to run into somebody somewhere else.

Q. And you said it was the SQL server?

A. Yes.

Q. S-E-Q-U-E-L?

A. S-Q-L.

Q. And what does the SQL server do?

A. It is the -- it's a database software.

Q. A database software for OARRS?

A. For the -- we keep a copy of data for research at the board of pharmacy, and that's what it resides on, but it is also the database software that the wholesale side would also run on.

Q. When you say, "We keep a copy of

the data for research at the board," what do you mean by that?

A. That would be a copy of the prescription data. So because the prescription side of OARRS is cloud hosted, we keep a local copy of the data for any kind of analysis and reporting we do.

Q. You mentioned that the wholesale side resides on SQL; did I understand that correctly?

A. Yes.

Q. And what if any wholesale-side data for research is maintained by the board?

A. Well, there is a set -- so there is the production copy, there is a separate research copy. We don't do -- we don't do the analysis on the production system.

Q. When you say, "We don't do the analysis on the production system," who is the "we"?

A. It would be me and my staff.

Q. And when you say that a copy of the data for research resides on the SQL database, what research do you mean?

A. Any type of analysis that we need

to do, if we are assisting compliance with an investigation or doing any other type of statistical reporting.

Q. When you say you would use -- or the research that you and your staff would do, and it is you and your staff that would do the research?

A. Yes.

Q. When you talk about the research that you and your staff would do on compliance with investigations, what type of investigations are you talking about?

A. It could be a number of types of investigations. It could be an investigation against a prescriber, a pharmacy, anybody that we license, it could also be a criminal case against a patient.

Q. When you are doing research for an investigation against a prescriber, can you call to mind a specific instance of an investigation against a prescriber, where you and your staff did research?

A. Sure. Yes.

Q. In that case, where did the investigation originate?

A. The specific case originated with OARRS, but they can originate in a number of areas.

Q. In the instance you are recalling where the investigation originated with OARRS, how does an investigation original in OARRS; how does that happen?

A. State law requires -- requires the board to monitor OARRS data for potential violations of drug law, and so as such, there are occasionally such violations, potential violations may be found in the data.

Q. Who is monitoring OARRS to see whether there is cause for an investigation?

A. It would be me and my staff.

Q. How do you do that?

A. Many, many different ways. We have a number of -- a number of statistical models that we use, as well as, you know, tips from investigators or, you know, if we see something in the news that we can possibly see if anybody else is doing this. There are many, many different ways.

Q. When you testified that there are statistical models that you and your staff use

to monitor the data, are those statistical models built into the OARRS database?

A. No. They are -- they would be custom code that we write in the office.

Q. Have you written custom code in the office for a statistical model that could be used to monitor the data on OARRS?

A. Yes.

Q. How much -- or how many statistical models -- strike that.

How many variations of statistical models do you use to monitor the data from OARRS?

A. I couldn't tell you. There are too many.

Q. More than a hundred?

A. Likely.

Q. More than a thousand?

A. Maybe not.

Q. More than 500?

A. I'd say somewhere between 100 and 500.

Q. So you and your staff use between 100 and 500 variations of a statistical model to monitor OARRS, correct?

A. Correct.
Q. And you and your staff wrote the code for all of those 100 to 500 statistical models?
A. Yes.
Q. What if anything determines which statistical model you would run in a particular investigation?
A. It would determine -- I mean, it would be -- I mean, if an investigation was already started, it would be whatever it was that was being found in the investigations, the findings.
Q. You said that investigations could originate through OARRS, but could also originate in a number of other places; do you recall that?
A. Yes.
Q. What other places could an investigation into a prescriber originate?
A. It could come from a complaint from the public, it could be something an agent or an inspector has come across. I'm sure there is many more. That's not really my area.
Q. When you say agent or inspector

could originate an investigation, is that an agent or inspector of the BOP?

A. Yes.

Q. When you say that a complaint can originate from the public, what do you mean by that?

A. We have a -- on our website, we have a public complaint form.

Q. How many public complaints have you received, during your tenure as the director of OARRS?

A. I wouldn't know. Those don't come to me.

Q. Who do they go to?

A. The director of compliance.

Q. Who is the director of compliance?

A. Eric Griffin.

Q. How many investigations have you and your staff participated in, while you have been a director of OARRS, that have originated from a public complaint?

A. I don't always know where they originate from, so I don't know.

Q. Do you have in mind any complaints that have originated from the public, that you

have participated in, during your time as the director of OARRS?

A. I can definitely think of one, yes.

Q. How recently?

A. This particular one would have been three or four years ago.

Q. Other than the one complaint you have in mind from three or four years ago that you know originated from a public complaint, can you think of any other occasions when you and your staff have investigated a complaint that originated from the public?

A. Not that I'm aware of. Like I said, I don't always know where they start.

Q. Other than public complaints, complaints that may have originated from an agent or inspector from the board of pharmacy or that arise from your own data monitoring, are there any other origination points that would lead to an investigation of OARRS data by you and your staff?

A. I don't know the answer to that. I wouldn't know the complete list. That's more of a compliance and enforcement area.

Q. So will you please walk me through

how, in the event you are investigating a complaint, as opposed to your data monitoring of OARRS, you get involved in that complaint?

A. Uh-huh. So typically, either somebody comes to my office or sends an email or calls me and describes what it is that they need, and I either, you know, depending on everybody's, you know, workload at the time, either I decide to do it myself or I assign it to one of my staff.

Q. When you say someone calls you or comes to your office --

A. It would be a -- it would be a member of the compliance staff.

Q. And that's Mr. Griffin's staff?

A. Yes.

Q. Have you ever investigated a complaint that originated from law enforcement?

A. No, not directly to me from law enforcement. It may have -- it may be something that the compliance department is working with law enforcement on, but anything that we would work would have come from our internal staff.

Q. So if the Cuyahoga Sheriff's

Department wanted to investigate a prescriber --

A. Yes.

Q. -- they would not reach out directly to you?

A. They may have -- they may have an account for OARRS, where if they just need a list of prescriptions that a prescriber wrote or prescriptions that a patient has received, they, by law -- they are permitted to have access to that if they have an open case for a drug investigation. And so they have an account where they could request that report, and the report would be created.

All of that happens automatically. It's not something that I would personally be involved with.

Q. When you say that the sheriff may have an account for OARRS and they can access a prescription that is a written or received, but it happens automatically, what do you mean by that?

A. So the -- you know, so the law enforcement officer has a case for a drug crime against a specific patient. They would have an

account where they can log in to the web interface for OARRS. They would enter in the information about the individual that they are investigating, including their case number. They would have to submit that.

They have to have a supervisor, who also has an OARRS account, who would approve that. Then the system would automatically generate the report for them.

Q. How long does that take, do you know?

A. Seconds.

Q. How long does it take you or your staff to run a statistical model on any of the -- on the OARRS data?

A. It depends on the model and the data range that we are looking at. It could take anywhere from a few seconds to hours.

Q. So we were talking a little bit about prescribers. Is the process for investigations of pharmacies the same as it is for a prescriber; that is, you monitor -- your office monitors the database, the OARRS database, to discover information about a pharmacy?

A. Yes.
Q. And likewise, you and your staff can run statistical models on the OARRS data pertaining to a particular pharmacy?
A. Yes.
Q. Can complaints about a particular pharmacy originate from the public?
A. Yes.
Q. Can complaints about a particular pharmacy originate from a BOP investigator or agent?
A. Yes.
Q. Are there any other ways in which your office would be involved in the complaint about a pharmacy, other than through the monitoring of data by you and your staff, or from a complaint from the public or an investigator?
A. Again, I assume that there are other sources, but I wouldn't know those.
Q. And by "other sources," you mean, perhaps, law enforcement?
A. Quite possible. Again, that's more the compliance department.
Q. So as with the complaints against

prescribers, complaints against pharmacies generally or typically come through the compliance department to you?

A. Yes.

Q. Have you ever investigated a pharmacy, other than in response to a complaint that has come through the compliance department?

A. Ones that we have discovered in OARRS directly.

Q. How many times have you discovered a pharmacy that requires some investigation through your OARRS data monitoring?

A. I don't know that I can put a number on it. Maybe -- I don't know. Fewer than a hundred.

Q. Do you know how many you have done this year of a pharmacy, investigations to a pharmacy that arose other than through a complaint that came by the compliance department?

A. Maybe five or six.

Q. You mentioned that OARRS -- you monitor data in the OARRS database for potential violations; is that the right word?

A. Uh-huh.
Q. By licensees; do you recall that?
A. Not always by licensees, but it is potential violations of drug law, period.
Q. I believe the term "licensee" was yours, but maybe it wasn't.
There are licensees of the board of pharmacy, correct?
A. Correct.
Q. Are there licensees other than prescribers and pharmacies?
A. Wholesale distributors.
Q. Anybody else?
A. Pharmacists, home medical equipment. I don't know the entire list. I know the ones I deal with most frequently.
Q. Are the manufacturers licensees of the board of pharmacy?
A. If they -- if they ship drugs directly into the state, yes.
Q. When I'm talking about manufacturers, I'm talking about manufacturers of opioid medications, okay?
A. Yes.
Q. Does that change your answer at

all?

A. No.

Q. Have you participated in any investigations of board of pharmacy licensees?

A. Yes.

Q. When?

A. The various times that we have discussed.

Q. Okay. Thank you.

So other than what we have discussed about prescribers and pharmacies, has the board of pharmacy -- strike that.

Other than the investigations about prescribers and pharmacies we have discussed, have you and your staff participated in any investigations of wholesale distributors?

A. Yes.

Q. When?

A. Numerous times.

Q. This year have you, in 2018, have you participated in any investigations of wholesale distributors?

A. Yes.

Q. How many?

A. Well, I don't know whether there

are multiple investigations or if it was all one. I'd say at least two.

Q. And the two investigations of wholesale distributors that you have in mind, were those originated from you and your staff's monitoring of data?

A. No, they were not.

Q. Were -- did either of them originate from the office of compliance?

A. They both would have.

Q. Other than the approximately two investigations of wholesale distributors that you can call to mind for 2018, how many investigations of wholesale distributors do you recall participating in, in calendar year 2017?

A. I don't recall.

Q. More than five?

A. I really don't remember.

Q. Other than the research that we have just talked about that is done on the wholesale side for the purpose of investigations, what if any research does you and your -- do you and your staff conduct on the OARRS data?

A. Specifically to the wholesale side?

Q. Let's start with that, please.

A. Honestly, we have spent more time on the prescription side than the wholesale side, but typically -- typically on the wholesale side, any of our research is going to be for the purpose of either assisting in an investigation or monitoring for potential -- potential crime.

Q. On the prescription side, so the prescription data, you mentioned that you keep a copy of the data at the BOP for any analysis or reporting; do you recall that?

A. Yes.

Q. What analysis do you do on the prescription-side data?

A. So we do a lot of analysis on the prescription side. We do -- there is analysis for statistics that get published in our various reports, annual and semiannual reports; statistics that get published to our website. We also do analysis to inform changes in various rules.

We, again, do analysis for, you know, for looking for potential crime, as well as -- as well as assisting in investigations.

We do research to identify individuals who may be at risk, based on the prescriptions that they take.

And then we do analysis for -- you know, we have a number of different grants that have different reporting requirements, and so we have to do analysis to produce those reports.

Q. You mentioned that the prescription-side data that is maintained at the BOP is also used for various reporting. Is there any reporting that you and your staff do with the prescription-side data, other than this list of analyses you perform that you just gave me?

A. There may be something that's not coming to mind, but those are what come to mind.

Q. Before I get through all this, do you want to take a break now? Are you ready for a break?

MS. BROWNE: How are you doing, Wendy?

Okay. Can we take about a seven-minute break?

MR. WAKLEY: Yeah.

THE VIDEOGRAPHER: Off the record. 9:28.

(Recess taken.)

THE VIDEOGRAPHER: On the record, 9:41.

Q. Welcome back, Mr. Garner.

When we went off the record, we were talking about the data analyses that are performed by you and your staff on the prescription side of the OARRS database; do you recall that?

A. Yes.

Q. One of the analyses that you perform are statistics and various reports -- oh, I'm sorry -- annual and semiannual reports; do you recall that?

A. Yes.

Q. When you say, "Annual and semiannual reports," what do you mean?

A. We have various reports, some of them are mandated by our legislature but -- that we produce either ever six months or every 12 months, and they are posted to our website.

Q. Other than the annual and

semiannual reports that you post to your website, are there other various reports for which you and your staff perform statistical analysis on the OARRS database?

A. There are, yes. There are a number of reports. There are quite a few on our website, but there are also some reports that we have created, several that run automatically on a scheduled basis, as well as others that we may be requested to create ad hoc.

Q. When you say there are reports that are run automatically on a scheduled basis, what do you mean?

A. There are reports that we have written that the server automatically creates and sends to various recipients, by email, on a scheduled basis. So, say, monthly, typically, monthly or weekly.

Q. I apologize. What reports are run on a scheduled basis, coming from the prescriber-side data on the OARRS database?

A. There are a couple of -- a couple of investigative reports, that would be a couple of key statistical models that we know are impactful that would go to compliance

staff.

We have also got some that track progress on a couple of projects we are working on.

Q. When you say there are a couple key statistical models that you know are impactful that go to compliance staff, what do you mean by that?

A. We have one that is -- that identifies doctor shoppers, we have one that identifies -- it's one of the -- one indication of overprescribing.

Q. Other than the investigative reports that identify doctor shoppers and that indicate overprescribing, are there other investigative reports that you and your staff run on the prescriber side of the OARRS database?

A. In an ad hoc manner, yes, but none that are scheduled and run automatically.

Q. For how long has the OARRS database been able to produce reports that identify doctor shoppers?

A. I don't remember when I started that. That was -- it was probably 2008, 2009.

Q. For how long has the OARRS database been able to run reports that indicate overprescribing?

A. That report I would have done -- I want to say it was 2012.

Q. With reference to both the doctor-shopping report and the overprescribing report, you testified, using the pronoun "I." Did you write the code for the doctor-shopping report?

A. Yes.

Q. Did you write the code for the report that can indicate overprescribing?

A. Yes.

Q. How long does it take for a doctor-shopping report to run?

A. You know, since it happens automatically, I'm not sure how long it really takes, but I would imagine it's less than two or three minutes.

Q. How long does it take to run a report that -- to indicate overprescribing?

A. That particular report, it would be very short.

Q. When you say "very short," would it

be a matter of minutes?

A. Probably less than a minute.

Q. You had mentioned, when we were talking earlier about, for example, the statistical models that you and your staff run that monitor the data on the OARRS database; do you recall that?

A. Yes.

Q. And we talked about there being perhaps 100 to 500 different statistical models that can be run; do you recall that?

A. Yes.

Q. You also stated that some of those models could be run in seconds; do you recall that?

A. Yes.

Q. How long has the OARRS database had the capability to run these reports in a matter of seconds?

A. I mean, it is a database. So, I mean, it takes a person to write the code, but, I mean, the software itself, I guess, has been capable all along. It just took somebody to make it do it.

Q. And the capability for these 100 to

500, approximately, statistical models to be run, for how long has the database had that, the software to make it capable to do that?

A. All along. I mean, that is -- I mean, database software holds data and allows you to retrieve data. So it's just a matter of somebody thinking of the particular model and requesting the data in that manner.

Q. And at what point did OARRS start running, for example, understanding it's been capable, but when did it start running the 100 to 500, approximately, reports for which you wrote that code?

A. So, I mean, some of them would have started at the very beginning, and we continue to add to it as time goes on and as we make various discoveries.

Q. And when you say, "At the very beginning," do you mean 2006?

A. Yes.

Q. The writing of, for example, the code that runs the 100 to 500 statistical models we discussed, did that require additional funding?

A. To the extent that I can't do it

all on my own, and so I have had to hire staff, yes.

Q. Do you recall hiring additional staff in order to write the code that runs the approximately 100 to 500 statistical models that we have discussed today?

A. Yes.

Q. You have hired additional?

A. Yes.

Q. Were the additional people you have in mind that were hired to write the code for the approximately 100 to 500 models contractors?

A. No.

Q. Are they -- were they employees of the BOP?

A. They are now employees of the BOP, yes.

Q. So the individuals who wrote the code for the approximately 100 to 500 statistical models we have been discussing today are currently BOP employees?

A. Yes.

Q. Were they hired specifically to write code?

A. Yes.
Q. How many folks is that?
A. Currently have -- I currently have one on staff, another getting ready to start.
Q. At any time did you have on staff more than one code writer?
A. Yes.
Q. When?
A. It would have been -- I'm so bad at remembering dates.
Q. That's okay. In the last five years, have you had more than one code writer on staff?
A. Yes.
Q. What is the maximum number of code writers you have had on staff at the -- devoted to OARRS?
A. Two, besides myself.
Q. We had also talked earlier in the context of investigations about a sheriff having an account for OARRS and being able to access information; do you recall that?
A. Yes.
Q. And you testified that they can request a report and -- they, the sheriff's

department, and after a supervisor approves it, a report can be generated within seconds; do you remember that?

A. Yes.

Q. How long has that capability been available in OARRS?

A. It has improved over time, so it originally was not seconds, but all along.

Q. And when you say "all along," you mean since 2006?

A. Yes.

Q. And the sophistication that permits these reports that we are talking about for law enforcement to run within seconds, how long has that capability been available?

A. I believe we got the time down to seconds in -- it would have been with the code changes in 2011.

Q. Did OARRS hire an additional code writer to optimize the system in 2011, such that sheriffs could run reports that we have been discussing in a matter of seconds?

A. No, we did not. That was me, and it's not just sheriffs. I mean, that applies to any OARRS user.

Q. When you say any OARRS user can run a report?
A. Yes.
Q. Do you mean prescribers?
A. A prescriber can run a report on their own patient, as can a pharmacist.
Q. Can a wholesaler run a report?
A. No.
Q. Can a manufacturer run a report?
A. No.
Q. Can a member of the public run a report?
A. A member of the public cannot run a report. A member of the public can receive a copy of their own report, by coming to our office.
Q. Other than law enforcement, prescribers, and pharmacists, are there any other entities that can run reports from OARRS?
A. There are. I can't remember them all, because it's been changed many times over the years.
Q. Do you know approximately how many entities can run reports from OARRS?
A. I want to say it's getting close to

20.

Q. And that includes law enforcement, correct?

A. Yes.

Q. Does it include the medical examiner?

A. The coroners?

Q. Yes.

A. Yes.

Q. Can the AG's office, the attorney general's office run reports?

A. Only the BCI has access right now, and again, it's only on a -- it's the law enforcement officer's role, so only if they have an open case on an individual.

Q. I'm sorry to interrupt you. Is BCI the Bureau of Criminal Investigations?

A. Yes.

Q. Can the governor's office access the reports -- run reports -- I beg your pardon.

Can the governor's office run reports from OARRS?

A. No.

Q. Does the governor's office have

access to OARRS?

A. No.

Q. Can the department -- the United States Department of Justice access OARRS?

A. Yes. Various agencies within the justice department, not everybody at the justice department.

Q. Do you know which agencies within the DOJ can access OARRS?

A. Typically the DEA. I'm sure that there are probably a few other agencies, but I couldn't tell you who they all are, off the top of my head.

Q. Is that written down somewhere, that is the agencies or entities that can access OARRS?

A. So state law is what ultimately determines who can and can't access OARRS. So that's always the guiding factor.

Q. But does state law actually enumerate by name the entities --

A. No -- I'm sorry.

Q. -- the entities that can access OARRS?

A. No, it does no.

Q. So I went off on a tangent there. Let me go back to the reports that you and your office run from OARRS.

A. Uh-huh.

Q. We have talked about the scheduled reports that include reports that identify doctor shopping and that indicate overprescribing.

How often are those reports generated?

A. Those two particular reports are generated monthly.

Q. And then, you said, there are reports that are generated on an ad hoc basis, correct?

A. Yes.

Q. Can you give me some examples of ad hoc reports that you have run?

A. So the director of compliance might ask for anybody who has purchased more than a certain number of units of drugs, would be an example.

Q. So to run a report that would identify anyone who has purchased a certain amount of drugs, what would you do?

A. So I would make sure that what I have been asked for is clearly defined, and if it is and is appropriate, according to statute, then I would -- I would run such a report.

Q. And when you say you would run a report, can you walk me through that literally, from I log on to the database to the report gets spit out?

A. So I would log in to my computer. I would open SQL Server Management Studio, which is where you write the code. I would write the code necessary to pull the data, I would typically copy it into the Excel spreadsheet, and either print it or email it to -- typically it is the director of compliance.

Q. So in the case of a report that would indicate anyone who has purchased a certain amount of a drug, you would actually have to write separate code for that report?

A. Yes.

Q. So you can't go in and fill out a field that you want to show up and then run a report that way?

A. No.

Q. Is there an interface on OARRS where a user, such as yourself, so you or your staff, could access a screen and, similar to like -- to a Google search, where you write, you know, such a subscriber, within, for opioid, and the report would generate for you?

A. No.

Q. We did talk about reports that are automatically run monthly, such as the doctor shopper or the overprescriber, correct?

A. Yes.

Q. The code has already been written for those, right?

A. Correct.

Q. And there is just a flag in the system that causes it to run monthly, correct?

A. Basically, yes.

Q. A human being doesn't go in and direct, every month, for that report to be generated, correct?

A. Correct.

Q. And the report, for example, the ID, the one that IDs doctor shoppers, that gets automatically delivered by email, you said?

A. Yes.

Q. And the reports that are run by law enforcement, for example, when we were talking about a sheriff wanting to run a report in an investigation, how does the sheriff ask for that report?

A. They have to go into -- they have to go to the OARRS website, log in with their credentials, they type in the name of the individual they are investigating and, depending on whether it is a prescriber or a patient, some other identifying information, they have to include a case number, and they submit it, their supervisor has to log in with their credentials to approve it, and then the system automatically generates that report.

Q. And is the same for pharmacists, for example, a pharmacist wants to see the report on a particular patient, are you with me?

A. Uh-huh.

Q. The pharmacist can log on with his or her login information, correct?

A. Correct.

Q. Enters the patient name, correct?

A. Correct.

Q. And then a report is run on that patient?

A. Correct.

Q. So it's not a case where if a pharmacist wants a report done -- run, the pharmacist logs in and contacts OARRS, being you or your staff, who then responds and sends a report, correct?

A. Correct.

Q. Other than the ad hoc reports -- well, let me ask you, are there any other ad hoc reports you can recall, other than, for example, if compliance asks for anyone who has purchased a certain amount of a drug that you recall running?

A. I've looked at what a prescriber or pharmacy purchases, versus what they reported dispensing.

Q. In the case of a report about what a pharmacy purchases versus what it dispenses, can a pharmacy run a report on what it has purchased?

A. No.

Q. Can a pharmacy run a report on what it has dispensed?

A. No.
Q. Can law enforcement run a report on what a pharmacy has purchased?
A. No.
Q. Can law enforcement run a report on what a pharmacy has dispensed?
A. Yes.
Q. And in the case of law enforcement running a report on what a pharmacy has dispensed, is it the same process we talked about, where the officer enters -- logs in to his or her account and identifies what it wants, a supervisor approves, and then the system automatically would generate the report on what a pharmacy has dispensed?
A. Yes.
Q. So in that situation, if you at OARRS wanted to run a report on what a pharmacy has dispensed, you would not have to write new code for that report, correct?
A. If that is all that I wanted, was a list of what they have dispensed, that is correct.
Q. It's when you want to compare what has been purchased to what has been dispensed

that you would then have to write code to generate a report, correct?

A. Correct.

Q. Going back to data analysis that is run on the prescription side of the OARRS database by you and your staff, you mentioned statistics on the website; do you recall that?

A. Yes.

Q. What if any statistics do you and your staff provide on the website that is based on data analysis that is done on the prescriber side of the OARRS database?

A. There are quite a few, actually. There are maps that show, by county, morphine milligram equivalents by per capita, as well as per patient. Also the number of prescriptions, opioid prescriptions per patient and per capita.

There is what we call the county spreadsheet, which is a spreadsheet listing all of the different counties and a number of both bulk measurements of prescriptions dispensed in that county, broken down by major drug classes, sedatives, stimulants, opiates.

Q. The maps and reports that we have

just discussed, the statistical reports that are available on the website, those are available to the public?

A. Yes.

Q. Are any of those that you have just listed for me available -- not available to the public?

A. No.

Q. Other than the maps that show the MME by county, by capita, per patient, the number of prescriptions per patient and per capita, the county spreadsheets, the bulk measurement of prescriptions dispensed in any county by drug class, are there any other reports that you and your staff routinely generate from prescriber-side data that are available on the website?

A. There may be. I don't -- I don't recall.

Q. You also mentioned that you and your staff run analyses on the prescriber-side data about changes -- regarding changes in various rules; do you recall that?

A. Yes.

Q. What do you mean by rules?

A. Those would be administrative rules, so the Ohio Administrative Code.

Q. Can you give me an example?

A. A year ago, maybe a little more than a year ago, the various prescriber boards were discussing changes to the administrative code, to basically set limits on the amount of an opioid that could be prescribed for acute pain for the initial prescription.

We used OARRS data to help -- to help guide that discussion to the specific numbers that they came to.

Q. Who is the "they," in that sentence?

A. Those would be the staffs of the various -- the various boards.

Q. And what various boards do you mean?

A. That would be the medical board, the dental board, and the nursing board.

Q. So when the change to the Ohio code to set limits on the amounts of opioids for initial prescriptions for acute pain were in the process of being codified, the staffs of the medical board, the dental board, the

nursing board and the board of pharmacy met; is that right?

A. Yes.

Q. Was that at the direction of the legislature?

A. I don't know. I was simply asked to provide the statistics. I was not part of the meetings.

Q. To whom did you provide those statistics?

A. The executive director of the pharmacy board.

Q. Can you think of any other occasion where analyses was performed by you and your staff on the prescriber side of the OARRS database for the purpose of a change in any rule?

A. We recently did some analysis as we were -- as we were changing the rule for reporting suspicious orders.

Q. What is a suspicious order?

A. I don't know that I know the entire legal definition of a suspicious order, but it would be an order that is -- that would be unexpected, for one reason or another.

Q. When you say your understanding is that it is an order that is unexpected for one reason or another, expected by whom?

A. It would be expected by -- by the wholesaler, I guess.

Q. And it is an order by whom?

A. By a wholesaler's customers.

Q. And what is the rule change for reporting suspicious orders that -- for which you ran some analysis of prescriber-side data?

A. I don't recall what the final rule ended up being.

Q. When was this?

A. It was earlier this year, late last year.

Q. And for the purpose of running an analysis -- well, let me ask you, who asked for the analysis related to this change in the rule for reporting suspicious orders?

A. It would have been our director of policy and communications, as well as the director of compliance.

Q. Who is the director of policy and communications?

A. Cameron McNamee.

MR. FARRELL: Counsel, I apologize. This is Paul Farrell. To save time later, I got lost. Are we talking about prescriber side or wholesaler side? It seems like we just jumped back and forth, and I got lost.

MS. BROWNE: Yeah. I asked him about prescriber side, and we're going to get to wholesaler side.

A. I'm sorry. Then I was answering your question incorrectly, because that would have been on the wholesaler side.

Q. So let me back up.

What if any analysis on the prescriber side of the database did you do related to the potential rule change for reporting suspicious orders?

A. There would have been none.

Q. And what if any analysis did you do on the wholesaler side of the OARRS database for the purpose of a rule change related to the reporting of suspicious orders?

A. So we looked at the history of purchases and looked to identify anomalies in the purchase information, so various statistical models, regressions and such, that

would show what you should be expecting a customer to purchase, based on their history and, you know, variances from that.

Q. When you say you looked at anomalies in purchasing history, what do you mean by that?

A. It would be where a specific customer is purchasing a drug on a routine basis that -- where a pattern can be identified, yet they make a purchase that is outside of that pattern.

Q. And you said that you ran various regression analyses to determine the expectations of what would be purchased, correct?

A. Yes.

Q. Who wrote the code for the regression analyses?

A. Some would have been written by me, some by my staff.

Q. And this report -- reports related to the suspicious order rule were done, you said, probably late 2017 or early 2018?

A. Yes.

Q. After you ran the reports at the

request of Cameron McNamee and/or Mr. Griffin, did you hear anything else, after the reports were run, related to the rule change on suspicious orders?

A. No, not directly.

Q. Indirectly?

A. My staff was more involved with it than I was. So, no, I did not.

Q. Did your staff report to you anything -- anything else related to the rule change for reporting suspicious orders?

A. No.

Q. When you say that not directly you knew more about the rule change for reporting suspicious orders, what did you mean?

A. I mean that I assume my staff had further conversations, but I wasn't involved.

Q. Why do you assume your staff had had further conversations?

A. Because I assigned them to that, to that process.

Q. Do you have meetings with your staff?

A. Occasionally.

Q. Are they scheduled?

A. No.
Q. Does your staff report to you?
A. Yes.
Q. Do they report to anybody else?
A. Sometimes to the executive director.
Q. And has anyone on your staff advised you about anything related to the change in the rule for reporting suspicious orders or work they have done therefor?
A. No.
Q. Do you expect them to?
A. Not necessarily.
Q. Why not?
A. I would expect them to report to me if there was some sort of an issue that they needed me to help resolve. If no such issues came about, then I would expect them to finish the tasks that were assigned.
Q. You said you additionally run reports on the prescriber side of the OARRS database for the purposes of analysis of a potential crime; do you recall that?
A. Uh-huh.
Q. What did you mean by that?

A. I'm sorry. Which side are we talking about?

Q. This is prescriber side.

A. Prescriber side. Again, there are a number of different ways that we do this, you know, looking for overprescribing sometimes of specific drugs or combinations of drugs.

It could also be, you know, violations by a patient, different things that would indicate overuse or misuse. Also, you know, dispensing patterns, dispensing combinations of drugs that would be ill advised. A pharmacy that maybe should have seen something and stopped it that did not, would be another. There are many, many different things we could look at.

Q. Okay. So on the prescriber side, you've identified some analyses that you and your staff are able to do on the database that indicate potential crime, such as the overprescription of drugs, the prescription of dangerous combinations of drugs, et cetera, right?

A. Correct.

Q. How long has the OARRS database

been able to do this type of analysis?

A. Again, the database has always been able to do it. It was a matter of staff -- having the capacity within the staff of doing it.

Q. And at what point did OARRS have the staff capacity to run the types of reports we just discussed that are indicative of potential crime?

A. We've -- we've done, to a certain extent, all along. It's just it has grown. It's not, you know -- it started small and it has grown over time.

Q. Does OARRS run or perform analyses of the wholesale side of OARRS for the purpose of identifying potential crime?

A. Yes, at times.

Q. And what types of analyses are those that are run on the wholesale side?

A. It could be purchases, especially by prescribers, of more drugs than they are permitted to dispense from their office in a given period of time; purchases that would not make sense for a particular type of prescriber; purchases that are not later reported as being

dispensed. It would be a few.

Q. On purchases by prescribers of more drugs than are permitted -- they are permitted to dispense, how do you, at OARRS, know how much a prescriber is permitted to dispense?

A. It is in the statute.

Q. It is an Ohio statute?

A. Yes.

Q. How frequently have you run or performed the analysis on purchases by a prescribers of more drugs than they are permitted to dispense?

A. It's on an ad hoc basis. I would say a couple times a year.

Q. And how many times have you run analyses of purchasers -- or purchases that do not make sense for the type of prescriber?

A. A handful of times.

Q. You mentioned that you also run analyses on the prescription side of the OARRS database when assisting with investigations; do you recall that?

A. Yes.

Q. We talked earlier about some reports that are run in the context of

investigations, such as the ones that come from the 100 to 500 statistical models; do you recall that?

A. Uh-huh.

Q. When you testified about reports or analyses that are done on the prescription side of the OARRS database related to investigations, were you talking about analyses other than those we have already discussed?

A. No.

Q. So in other words -- because that was a mouthful -- are there analyses that are run by you and your staff on prescriber-side data from OARRS, in the context of an investigation, other than that to which you have already testified?

A. Not that I can think of.

Q. Are there analyses that you run on wholesale-side data to assist in investigations, other than the reports we have already discussed?

A. None that I can think of off the top of my head. There could be, but...

Q. If you think of any reports related to investigations that you and your staff have

run on wholesale-side data, other than what we have already discussed, will you just interrupt me at some point and raise it, if you think of it?

A. Absolutely.

Q. Thank you. You said that you also run reports on prescriber-side data to research and identify individuals at risk based on the prescriptions they take; do you recall that?

A. Yes.

Q. How do you do that?

A. Again, there are a number of different ways that we do that. Some of them based on morphine milligram equivalents, some of them based on numbers of prescribers and pharmacies, some actually get into an entirely different way of looking at data, using machine learning models, combinations of drugs.

Q. Are there -- is there analysis that is done on the wholesaler side of the database to research and identify individuals who may be at risk, based on prescription they take?

A. No.

Q. So reports that are run based on MME, morphine milligram equivalent, how do you

run those reports?

A. Those are, again, ad hoc reports that we would write code for.

Q. And reports that analyze the number of prescriptions and pharmacies from which a particular patient is obtaining medication, are those ad hoc reports?

A. Aside from the one that is scheduled on a monthly basis, we also have ad hoc reports that we would run.

Q. And do you have to write code for that?

A. Yes.

Q. You also mentioned machine learning models that are run?

A. Yes.

Q. Can you tell me a little bit about your machine learning models?

A. Those are, to date, comparing the prescription histories of overdose decedents with living patients, to see which patients are most at risk of overdose.

Q. How did you come to run an analysis of the history of overdose decedents versus live patients, to see those at risk of

overdose?

A. I'm not sure I understand. How --

Q. Did someone request that your office run that analysis?

A. No.

Q. Why did you run that analysis?

A. Because ultimately the -- the mission of the board is to protect the public, and protecting them from overdose would certainly fit within that mission.

Q. Did the idea to use machine learning to run the analysis on overdose deaths, versus live patients to determine likelihood of overdose, come from someone within the BOP?

A. The idea of using machine learning would have been my own, and that would have been through my master's program, is where I worked with machine learning.

Q. And does using machine learning cut down on the time it takes to run some of these reports?

A. No, not at all.

Q. So what is the purpose of machine learning?

A. It is able to find patterns and compute -- compute so many different possibilities, to find the patterns in a way that, as a human, we would not think of them all.

Q. And is the BOP currently using machine learning with the OARRS database to run reports?

A. So there is a machine learning -- so the patient report that a -- that a pharmacist or a prescriber would get, there is a score on that report that is based on a machine learning model. That is not any ones that we created in the office. That was created by the vendor. But otherwise, no, not currently, based on our models.

Q. Is that the NarxCare score?

A. Yes.

Q. We will talk about that in a minute, but the NarxCare score is -- who can run a NarxCare score, on a particular patient?

A. That would be a healthcare professional, so a pharmacist or physician or their delegates.

Q. Can you or your staff run a

NarxCare score, on a particular individual?

A. Yes.

Q. Can any other -- let me back up.

We had talked about how state law determines who can access OARRS; do you recall that?

A. Yes.

Q. So could any of the entities who can access OARRS pursuant to state law run the NarxCare score of a particular individual?

A. Currently, only the healthcare professionals.

Q. Is there any machine learning that is used on the wholesaler side of the OARRS database?

A. No, not to date.

Q. You also noted that analyses are run to the prescriber side of the OARRS database by you and your staff for the purpose of reporting requirements under various grants; do you recall that?

A. Yes.

Q. What if any grants were you referring to?

A. We have -- OARRS is primarily grant

funded. So we have a number of grants that we receive, particularly through the federal government, the Bureau of Justice Assistance, the CDC or SAMHS, which I'm trying to remember exactly what that stands for, Substance Abuse Mental Health something Administration.

Q. Right. Do you know how many grants OARRS is currently the beneficiary of?

A. At least three, less than six.

Q. And what are the reports that are required for receipt of the funding under the three to six grants that OARRS currently is the beneficiary of?

A. Each department has a different -- has a different report that they require. Typically, they are numeric questions for about how many people use the system, how they use the system, as well as, again, some of those key, you know, number of doctor shoppers, by their specific measurement of what is a doctor shopper, and sometimes it is broken into drugs, DEA drug schedules.

Q. Is the data, the reports that are provided to the various granters, anonymized?

A. There is no -- they are aggregated

at a state level. So they are just numbers.

Q. And for example, identifying the number of doctor shoppers for, you know, a federal grant, how long does it take to run that report?

A. A few minutes.

Q. So getting back to my original question that got us here, you mentioned that in addition to vendor relations and running reports from OARRS, you are also responsible, in your role as the director of OARRS, for staff management; do you remember that?

A. Yes.

Q. Can you tell me what the responsibilities are that you have related to staff management?

A. So I have currently three employees that report to me, and so I approve their schedules, approve any time off, I assign tasks as necessary, assist them with anything that they need assistance with. I mean, basic management duties.

Q. And what are the roles of the three employees that report to you?

A. We have a pharmacist who does some

customer service, as well as any time -- you know, me not being a pharmacist, any time that I have a question that would be more the practice of pharmacy, that I -- you know, she would help me with that, and she does a number of other things outside of OARRS.

I have an administrative assistant, who does customer support. She also does administrative tasks for me, booking meetings and so on and so forth. And then we have a data analyst, who helps me with the various reports and statistics that we have been discussing.

Q. And is the data analyst the individual who assists with writing code?

A. Yes.

Q. And you said you are in the process of hiring another data analyst; is that right?

A. Yes.

Q. Will that increase your staff to four?

A. Yes.

Q. Is the new data analyst position intended to replace somebody else on your staff?

A. No.

Q. You also mentioned, in your role as director of OARRS, that you participate in various public speaking events, correct?

A. Correct.

Q. Is there -- can you give me an example of some of the public speaking you have done, as the director of OARRS?

A. I just gave a presentation at NASCSA, National Alliance of State Controlled Substance Authorities. I just did that last week -- or two weeks ago. I have spoken at BJA's grantee meetings.

Q. What does that stand for?

A. Bureau of Justice Assistance.

I spoke -- I have spoken before various groups of prescribers and law enforcement around the state.

Q. What was your presentation to the National Alliance of State Controlled Substances Authorities about?

A. It was about a grant project that we currently have -- that we have, about how we do data analysis to identify crime in the OARRS data.

Q. Is that presentation publicly available?

A. Yes, it is.

Q. And you also presented to the BJA at a grant meeting; is that correct?

A. Yes.

Q. And what was the topic of that presentation?

A. That was a different project that we've got for a grant that -- where we identify individuals who -- who are, for lack of a better term, doctor shoppers, and we have two agents who then perform interventions to try to get them into treatment.

Q. You said, for "Lack of a better word, doctor shoppers." Is there another term that is used by the BOP to describe doctor shoppers?

A. That is the term that is used, but doctor shopping is not necessarily the only indication. You know, that is an indication of drug abuse, but there are others that are also used.

Q. Such as?

A. The amount of drugs that the

patient is taking, combinations of drugs, you know, historical patterns.

Q. And doctor shopping can be recognized through the use of the OARRS database, correct?

A. Yes.

Q. Can the amount of drugs that a patient is using be revealed through the OARRS database?

A. Yes.

Q. And can the OARRS database reveal combinations of drugs taken by a particular patient?

A. Yes.

Q. Are you responsible for writing the grant proposals?

A. No.

Q. Who does that?

A. Cameron McNamee.

Q. Do you have any input on the grants for which you apply?

A. Yes.

Q. What input do you have into the selection of grants that you will apply for?

A. Typically, I typically have a

meeting with Cameron to discuss, you know, possibilities for projects that could be funded.

Q. You mentioned that -- I think you said most of the funding for OARRS comes from grants and the federal government; is that right?

A. Yes.

Q. What if any percentage comes from the state, do you know?

A. What would come from the state would come from board of pharmacy licensure fees. Nothing comes from the general budget.

Q. You mentioned in your role as the director of the board -- I beg your pardon -- the director of OARRS that you also attend various meetings, correct?

A. Yes.

Q. What meetings do you attend?

A. More than I could possibly tell you. So it could be meetings with Medicaid or with the department of mental health and --

Q. That's SAMHS?

A. Well, the state version. So we call them OMHAS, and I'm trying to remember

what that stands for, Mental Health and Addiction Services. That's it.

It could be meetings, you know, internal meetings with board staff, it could be meetings with -- it could be meetings with prescriber groups. Many different meetings.

Q. When you have met with Medicaid, what do you meet with them about?

A. Typically, it is about what we are both seeing in data. We do some joint projects at times to -- to see, you know, whether we are seeing the same types of patterns in both systems.

Q. Does Medicaid have -- does the department of Medicaid have access to the OARRS database?

A. They have access only to the patients who receive Medicaid benefits, and only on a patient-by-patient basis.

Q. Are you aware of a movement or proposals by Medicaid to provide private insurers with access to OARRS?

A. If it is an movement by Medicaid, do you mean their -- what do they call those -- their managed care organizations, which would

be public insurers --

Q. Yes.

A. So those specific ones who are contracted by Medicaid --

Q. Contract insurers, correct.

A. They do have access. They were provided access a number of years ago.

Q. Other than the contract insurers through Medicaid, are there other private insurance companies that can access OARRS?

A. No. Medicaid or BWC has the same. So their's can as well.

Q. What is PBC?

A. Bureau of Workers' Compensation.

Q. Oh, BWC. I'm sorry.

When you meet with OMHAS, the Ohio Mental Health and Addiction Services, what has that been about?

A. So again, that would be about patterns that they are seeing, that they are hearing about. They have access to a deidentified set of data that we have provided, so that they can monitor different abuse patterns there as well.

Q. Okay. And then you said that you

also will meet with various prescriber groups, correct?

A. Correct.

Q. And what types of meetings do you have with various prescriber groups?

A. That can vary. It can be anywhere from a training type of session to meetings where they are floating an idea, basically.

Q. When you say "training session," is that a training session on OARRS?

A. Yes.

Q. You mentioned the House Bill 93 earlier; do you recall that?

A. Yes.

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(Thereupon, Deposition Exhibit 3, November 21, 2011 Report on House Bill 93 by William Winsley and Danna Droz, was marked for purposes of identification.)

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Q. I'm going to show you what we have marked as Exhibit 3. This is a copy of a November 21, 2011 report on House Bill 93 by William Winsley and Danna Droz.

A. Yes.
Q. Have you seen this document before?
A. I am sure that I have.
Q. Who is William Winsley?
A. He's the former executive director of the board of pharmacy.
Q. And who is Danna Droz?
A. She is my predecessor as the director of OARRS.
Q. And you understand that in 2005, Ohio enacted a law that allowed the board of pharmacy to develop its own PMP?
A. Correct.
Q. And that led to the 2006 release of OARRS, correct?
A. Correct.
Q. Do you know why OARRS was established?
A. Because the board of pharmacy, along with the legislature, recognize that there was a prescription drug problem and, ultimately, at that point in time, there was no way of monitoring it.
Q. OARRS monitors outpatient drug -- or outpatient prescriptions, correct?

A. Correct.
Q. So patients who are in the hospital, receiving medication from a hospital, are not included in the database, correct?
A. Correct.
Q. Are hospital pharmacies included in the database?
A. If they dispense outpatient prescriptions.
Q. If they do --
A. And that's on the prescription side of it.
Q. Okay.
A. On the wholesale side of it, we collect what is sold to all pharmacies. So even if they don't do outpatient prescriptions, we still receive what they purchase.
Q. And do you understand that OARRS was also intended to be an investigative tool for law enforcement?
A. Yes. I mean, it is a healthcare tool first, a law enforcement tool second, but, yes.
Q. Prior to the creation of OARRS, how did the state monitor patient information?

A. It was very difficult. An investigation would be opened first, and an investigator would have to go pharmacy to pharmacy and collect prescriptions.

Q. We've talked a little bit about, for example, legislation that identifies the entities that can access OARRS.

Are you aware of any legislation, other than the House Bill 93, since 2005 that has updated any OARRS capability?

A. Oh, yes. There has been a number, a number of times that it has been updated.

Q. Are you aware of legislation that addresses reporting requirements for users?

A. "Reporting requirements for users," I'm not sure I understand.

Q. Okay. We'll come back to that.

Do you know if other states have systems comparable to OARRS?

A. Yes.

Q. And do they?

A. Yes, they do.

Q. And do you understand that in all 50 states, except for Missouri, there are OARRS-type databases?

A. In all 50 states, besides Missouri, there is a statewide system. Missouri has a system. It is based in St. Louis County, and other counties are permitted to join it, but it does not have a statewide system.

Q. You mentioned that Appriss is the vendor for OARRS, correct?

A. Correct.

Q. Do you know how many states are -- for whom Appriss is the vendor of their PMP?

A. I don't know the exact number. I know it is more than 40.

Q. OARRS has the capability to run multistate queries, correct?

A. Correct.

Q. When did it gain that capability?

A. I don't remember the exact date. I want to say it was 2011.

Q. And the multistate PMP queries that OARRS can run, is that limited to border states?

A. That is not.

Q. Individuals -- strike that.

Entities that have access to OARRS,

based on the state mandate that we talked about earlier, or the legislation we talked about earlier --

A. Correct.

Q. -- do those entities have multistate access?

A. Not all. It is typically prescribers and pharmacists, but it is all determined by the laws and the state that owns the data, the state that we are sharing with. We each abide by each other's laws.

Q. We talked a little bit about software updates and changes in the evolution of OARRS related to report running, correct?

A. Correct.

Q. Related to the time it takes for a report to be run, correct?

A. Correct.

Q. Other than the evolution related to specific types of reports and the speed at which those reports can be generated, do you recall any other changes to OARRS that have been implemented over the years?

A. Well, clearly, the ability to access interstate reports would have been one

that I forgot about.

Q. Anything else, other than the ability to access interstate reports?

A. Well, I believe when you were questioning me about that, you were talking about my time as database administrator, so those would be those. However, since I have become director of OARRS, we changed software platforms entirely.

Q. Is there a database administrator for OARRS currently?

A. No.

Q. Does that -- does the responsibility for database administration fall under your jurisdiction now?

A. So the database administrator was -- much of that position was running the servers, and since the majority of that has now been moved to the cloud, it is now the responsibility of our vendor, rather than an individual in our office.

Q. And the vendor, who is the vendor responsible for that running of the cloud?

A. Appriss.

Q. Is OARRS now capable of collecting

more data than it was in 2006?

A. So the statute has always allowed us to collect controlled substances. Are we talking about prescription side or wholesale side?

Q. Well, let's start with prescription side.

A. Okay. The statute has always permitted us to collect controlled substances, and then any drugs of concern, as determined by administrative code, by the board.

Originally, there were two drugs that we collected as drugs of concern. Those were tramadol and carisoprodol. Those two drugs have since become controlled substances. We recently added gabapentin as a drug of concern.

Q. Why is that, that you added gabapentin?

A. There were a number of reports that we were hearing, both from public sources as well as -- as well as the Department of Mental Health and Addiction Services, that gabapentin was being abused. We were also hearing from pharmacists, and as time went on, we also then

started seeing gabapentin show up in coroner's reports from overdosed decedents, and as we gathered all that evidence and took it to the board, they determined it would be appropriate to start collecting that information.

Q. And when was that, that you began collecting the information on gabapentin?

A. I'm so bad with dates. It was --

Q. Since you have been director of --

A. Yes. I believe it was the end of 2016.

Q. Is the database capable of storing more patient data now than it was in 2006?

A. So as in physical capability?

Q. Correct.

A. Because it is cloud hosted, yes, I would certainly assume it is.

Q. On the wholesale side, is the database more capable -- I'm sorry, capable of collecting more data now than it was when you first instituted the wholesale side, which I believe you said was 2011?

A. No. The wholesale side was instituted in 2006.

Q. Okay. So has the wholesale side

evolved at all since 2006?

A. Yes. The statute originally required wholesalers to report the sales to prescribers only. It has since been updated to require the sales to prescribers and what in law is referred to as terminal distributors, so basically pharmacies, clinics and such.

Q. If you could turn to page 9 of Exhibit 3, which is that report on Bill 93 from 2011.

A. Uh-huh.

Q. At the bottom of the page, there is a section, Other Accomplishments, and the second sentence says, "For example, OARRS currently processes nearly 7,000 requests for reports daily, and 99.5 percent of these are handled automatically within three seconds"; did I read that correctly?

A. Yes.

Q. Do you know how many requests OARRS currently processes?

A. The last number I saw was for July, and it was 599,000.

Q. Per day?

A. Per day.

Q. And are those 599,000 requests per day also handled automatically within three seconds?

A. Yes.

Q. We have talked today about the statistical models that you and your staff have created, and we have talked now about the capability for interstate searching on OARRS.

We have talked about the increase in speed at which reports can be generated, and we have talked about the increase in types of reports that can be generated, since the inception of OARRS, correct?

A. Correct.

Q. Other than those things, can you recall any other capabilities that have developed in OARRS, since it was started in 2006?

A. So shortly after I became director of OARRS, we began adding morphine milligram equivalent information to the patient report.

After that, we upgraded to the new software platform, which did not initially provide new capabilities. It provided more system stability, the ability to grow, and

ultimately the ability to add NarxCare, which would be the latest enhancement, and the ability to -- we started also, shortly before moving to AWARxE, we started a project where we were integrating access to OARRS directly into the software of pharmacies and physician systems. But that really -- the ability to do that really sped up and took off, when we made the platform change.

Q. You mentioned the AWARxE platform, correct?

A. Yes.

Q. That's A-W-A-R-x-E; is that right?

A. Yes.

Q. All caps?

A. Yes.

Q. Except for the X?

A. Yes.

Q. When did you migrate to that platform?

A. That was in April of 2017.

Q. Is there information available through OARRS now publicly that wasn't available when the database originated?

A. I'm sure there is.

Q. Can you think of anything?
A. Any of the reports and such that are on our website were not on the original OARRS website.
Q. Does the website provide searching capability for OARRS for the public?
A. For the public, no.
Q. Why not?
A. So the searching identified information would not be appropriate, nor would it be legal for the public. Deidentified information, that may -- that may happen some day, but to date, just resources have not allowed.
Q. Okay.
MS. BROWNE: Have we been going for another hour again. Do you need a break? Okay, we will take a quick break.
THE VIDEOGRAPHER: Off the record at 10:59.
(Recess taken.)
THE VIDEOGRAPHER: On the record, 11:20.
Q. Mr. Garner, I wanted to just go about -- over some of the things that we talked

about in this last session, to get some clarification.

You had mentioned that you, at times, will write code to run various reports, correct?

A. Correct.

Q. Is another term for that code you write a query?

A. If the code is a direct -- is directly to the database, yes.

Q. When would you be writing code for a report that isn't directly to the database?

A. I may write code, so for instance, machine learning, that code would not be -- there would be a query in that code, but that code itself would not be a query.

Additionally, we use SQL Server Reporting Services, which has, you know, has more of a -- it has, again, the query built into it, but then also allows you to build a graphical, you know, layout and everything that is -- some of it is drag and drop, some of it you can write in other programming languages.

Q. When you write code to query the database to run a report, about how long does

it take you to write that piece of code?

A. It depends on the complexity of what we are looking at. A machine learning model can take days. A report can take -- a report in SQL Server Reporting Services can sometimes take day. A query that, you know, we are just pulling data directly and not in one of those tools, you know, minutes to hours.

Q. So if you were running the query to run a report on the number of prescriptions that a certain number of pharmacies was writing, how long would that report -- I beg your pardon -- how long would that query take to write?

A. So if I was to write a query about how many prescriptions a specific pharmacy filled?

Q. Yes.

A. That would take a few seconds, less than a minute.

Q. Also on this code issue, you mentioned that you wrote some -- or performed regression analyses to identify anomalies for -- for example, when we were talking about the rule on the change of suspicious order

reporting; do you remember that?

A. Yes.

Q. Who decided what regression analyses would be appropriate?

A. We tried various. I don't know that anybody made a decision that one or another would be appropriate. They were -- both me and my data analyst were both working on this, and so we ran various analyses in order to see which ones seemed to fit best.

Q. How did you determine which analysis fit best?

A. By reviewing the results and, you know, typically when you have a regression analysis, especially that type of analysis, you can graph it, and so whether the data fit the graph or not is typically a good indication.

Q. And after you and your data analyst determined the regression analysis to use, did you provide the various options to anybody else, or did you just decide amongst yourselves which was the best one to run?

A. There was a group, and this was where I, you know, assigned my data analyst, rather than attending myself, so I don't have a

lot of detail, but there was a group that was meeting that included my data analyst and a number of others from the compliance department that reviewed the different things we were finding.

Q. Are there data analysts in the compliance department?

A. Not the level of data analyst as what I hired. There are -- well, no, there is not currently.

Q. When you ran the statistical analysis on the data for the purpose of that new suspicious order rule, you did not run data on, for example, McKesson specifically, correct?

A. Correct.

Q. You didn't run it on ABDC specifically, correct?

A. Correct.

Q. You did not run it specifically on Cardinal Health, correct?

A. Correct.

Q. That's because you have access to aggregate data, correct?

A. Correct.

Q. And the aggregate data is going to provide you with more information than you would have if you just ran it on one distributor, correct?

A. Correct.

Q. And the wholesalers, like McKesson, Cardinal, ABDC, cannot access that aggregate data, correct?

A. Correct. And I'll correct myself, because we did at times run on individual wholesalers as well.

Q. Why did you run reports on the individual wholesalers?

A. Because of the fact that the wholesalers cannot see each other's information, you know, anything with the rule, we would have to keep that in mind.

Q. Is there any mechanism by which a wholesaler can access the data of another wholesaler?

A. Not that I'm aware of.

Q. Is there a mechanism by which a wholesaler can access its own data?

A. In OARRS?

Q. Yes.

A. No.

Q. Have any wholesalers ever been able to access data in OARRS?

A. No.

Q. We also were talking about, a minute ago, the wholesaler database and reports that it can run, reports that can be run on the wholesale side, and you mentioned that there could be a report of sales to prescribers; do you remember saying that?

A. Yes.

Q. Why -- when was it the case that OARRS would run reports of a wholesaler's sale to prescribers?

A. So that typically is -- there is a number of reasons, but one is the fact that state law limits the number of -- the amount of controlled substances that a prescriber can personally furnish from their office, and so one such query would be to see whether or not they were violating that.

Q. And when was it that the reports were being run only as to the prescribers, as opposed to now you said it is terminal distributors and prescribers?

A. Okay. So that is what is reported to us by the wholesalers. So the House Bill 93 legislation changed that.

Q. I see. Okay.

A. So basically before House Bill 93, we did not have access to what was sold to a pharmacy.

MR. EMCH: Sorry. Did you say 2011?

THE WITNESS: It was 2011 when that was passed, yes.

Q. You mentioned that one of the changes that came out over time was the ability for interstate queries, correct?

A. Yes.

Q. And you mentioned that some pharmacies and pharmacists can access some PMPs of other states, correct?

A. Health -- it is typically healthcare professionals, yes, that can access the information in other states.

Q. Are pharmacists considered healthcare professionals?

A. Yes.

Q. Are pharmacies considered

healthcare professionals?

A. We do not allow access to OARRS as a pharmacy, only as a pharmacist.

Q. How long has it been the case that pharmacists can access or make interstate queries?

A. It would have been 2011-ish, 2011, 2012, something like that.

Q. So prior to 2011, 2012, pharmacists and healthcare professionals were unable to access other state's PMP database?

A. There was the possibility that they could register for an account in another state. I know some did that, some have done it in Ohio as well, but there was -- there is no way for me to know how many or which states.

Q. Currently, for a pharmacist to have multistate access, does he or she have that access through their OARRS account?

A. Yes.

Q. But that was not the case prior to 2011, 2012?

A. Correct.

Q. We talked about reports that can be run by the pharmacist. Is the identification

of the individual who picked up the prescription tracked?

A. No, it is not.

Q. If a prescription is not picked up, so it is filled but not picked up, is that tracked?

A. The pharmacy is supposed to basically retract that information from OARRS, if they have already sent it. Most pharmacies hold onto the data, until the patient picks it up.

Q. What happens to a prescription, if you know, that doesn't get picked up?

A. I wouldn't know.

Q. Is there some mechanism in OARRS for the pharmacy to report that?

A. The mechanism would be -- so they -- a record that is sent to OARRS basically can be an insert and update or delete. So basically they would delete that prescription, since it was no longer dispensed.

Q. We talked about law enforcement having accounts and, for example, we talked about a sheriff that wanted to make a query.

If, for example, the sheriff of

Summit County has an OARRS account, is there -- do you or your staff have a way of monitoring how many times that Summit County Sheriff's account has been used to access OARRS?

A. Yes.

Q. Can you run a report that would show how many times any given OARRS accountholder accessed OARRS?

A. Yes.

Q. On the wholesale side of the database, I think you mentioned that -- we just talked about reports of prescriptions that are purchased. So the identification of purchasers of prescriptions is reported, correct?

A. Correct.

Q. What else is reported by the wholesaler?

A. The wholesaler reports, first off, who they are, so we know who the wholesaler is; the drug that was sold; how much of the drug was sold; when it was sold; and to whom it was sold; and an invoice number, just to track it.

Q. How long -- and those parameters to whom it was sold, the quantity, where it was

sold, et cetera, how long has it been mandatory that wholesalers report that information?

A. It's been mandatory since 2006. However, as I mentioned earlier, originally it was only the sales to prescribers.

Q. So all of that information was required, but only as to prescribers who are dispensing from their offices?

A. Correct.

Q. And then it was 2011 when they were required to report it also as to terminal dispensers?

A. Correct.

Q. You said that you can monitor, for example, the number of times an accountholder queries the database, correct?

A. Correct.

Q. Can you monitor the transactions themselves, so what the queries were?

A. Yes.

Q. For how long -- or how far back does that data go?

A. A long time. I want to say back to about 2014.

Q. Is there data -- the data that goes

back to 2014 on transaction history, where does that reside?

A. At the board of pharmacy.

Q. Is there a way to track or monitor queries that were made by a specific OARRS accountholder prior to 2014?

A. I may have it. It's all in the same place. If I do, I don't recall. At one point, we were purging that information. I don't recall when the last time was we did that.

Q. Why were you purging the info?

A. Just as a matter of maintenance, at the time, just the way we did things.

Q. Is there any requirement for the time, length of time for which you have to maintain, for example, transaction information of a particular OARRS accountholder?

A. No.

Q. So who determines, for example, that you have data back to 2014?

A. Currently, it's me.

Q. There are no guidelines for how long one should maintain the data pertaining to the history of a particular OARRS

accountholder?

A. No, there are not.

Q. Is there any other database in the state, other than OARRS, that is accessible to prescribers, that collects the type of data that OARRS collects?

A. No, not that I'm aware of.

Q. Is there any other database in the state that collects the type of data that OARRS collects that is available to dispensers?

A. Not that I'm aware of.

Q. Is OARRS available to hospitals?

A. It would not be to the hospital. It would be to the prescriber in a hospital or pharmacist in a hospital.

Q. So the pharmacist in a hospital-based pharmacy may have an OARRS account?

A. The pharmacist may, yes.

Q. Do you know if there is a PMP for the hospital systems in Ohio?

A. There is not a different PMP, no.

Q. So let's talk a little bit about the specific information that OARRS collects related to outpatient prescriptions.

A. Okay.
Q. So we are talking about the information that a pharmacy or prescriber is required to report.
A. Okay.
Q. Is the prescriber -- so for prescriber information, is the exact drug prescribed required to be reported?
A. They report the NDC code, which, yes, is the exact drug.
Q. Is that the Narcotic Drug Code?
A. National Drug Code.
Q. And are prescribers required to identify the quantity in grams of a prescription prescribed?
A. They report the quantity, based on whatever unit it is. So if it is a medication that is dispensed as a pill, it would be the number of pills. If it is a liquid, it is typically the number of milliliters. I don't know that I have seen powders dispensed directly, but then it would be grams.
Q. What about the MME?
A. The MME is calculated at OARRS. It is not reported by the pharmacy or prescriber.

Q. Are prescribers required to report the number of pills per prescription?
A. Yes.
Q. Are prescribers required to report the prescription strength?
A. That would be derived from the NDC number.
Q. Are prescribers required to report how often a particular drug has been prescribed?
A. Not how often. It's each prescription. So that --
Q. Does the prescriber have to report to OARRS the exact date the prescription is written?
A. Yes.
Q. Does the prescriber have to provide its specific name and address?
A. The prescriber or pharmacy, whichever did the dispensing, would report the DEA number of the prescriber.
Q. And then that's prepopulated in the field?
A. Right.
Q. Is the specialty of the prescriber

reported in the database?

A. It is not. Any specialty information that we have either comes from the medical board or from the prescriber themselves, on their OARRS account.

Q. Is the specific ailment for which the prescription is directed required to be reported?

A. Yes. That's a recent change.

Q. When was that change instituted?

A. December of 2017.

Q. The seven or eight requirements we already discussed, have those been in effect since the institution of the database?

A. With the exception of the diagnosis, yes.

Q. So the drug prescription strength, prescriber information, date of prescription, all had to be reported upon the release of OARRS in 2006, correct?

A. Correct.

Q. And the specialty of the prescriber, was that -- I'm sorry, was that also -- had to be reported?

A. It is not reported. We attempt to

get that information either from the medical board or from the prescriber themselves, but it's kind of hit or miss.

Q. Is a prescriber required to report the number of refills authorized?

A. Yes.

Q. Has that always been the case?

A. Yes.

Q. And is the prescriber also required to report the dosage of each prescription?

A. They would give the number of unit doses in the prescription. So the quantity, as we discussed. They give the number-of-days supply, so the number of days it should last, and that is calculated typically by the dispensary. If it is dispensed by the office or dispensed by the pharmacy, it is typically calculated there.

Q. And how long has that been the case?

A. Since day one.

Q. Is a copy of the label ever provided to OARRS?

A. No, it is not.

Q. Does a dispenser have to report the

exact prescriptions it has filled?

A. I'm sorry?

Q. So we talked a minute ago about when prescriptions are filled but not picked up, and you mentioned this ability to delete a prescription.

How frequently do dispensers have to complete reports?

A. They report daily.

Q. And in a daily report, if they are going to -- if a prescription is not picked up and they want to delete it, in what period of time does that deletion have to be done?

A. There is no hard-and-fast rule. Each pharmacy typically has its own -- its own rules for how long a prescription will stay in what they call will call. And so it would be when they remove that from will call and return it to stock, that's when they would also then report it back to OARRS, if they had already reported it.

Like I said, a lot of the pharmacies now have the ability to not report that until it is picked up. So that way they don't have to reverse it.

Q. Well, what's the requirement? In other words, if I'm Mo Browne's pharmacy, do I report -- my daily reporting requirement is to report the prescriptions I've filled or the prescriptions that left my pharmacy?

A. You know, it is not real clear, and so we have accepted either one. I mean, you know, as a program, we are more interested in what drugs the patient has in their possession than, you know, the drugs that are still sitting on the shelf in the pharmacy.

So our advice has been when they can, to report it when it leaves the pharmacy, but not all pharmacies are capable of doing that.

Q. Why would they not be capable of doing that?

A. Traditionally, in pharmacies, there are two separate systems. There is the dispensing system, which knows all about the prescriptions and, you know, the drugs and all of that. There is a separate point-of-sale system that is used to charge you for your prescription.

And it is that point-of-sale system

that knows when it leaves the pharmacy. The two have not typically -- they don't always talk to each other. It has changed over time, but in 2006 -- it basically just didn't happen ever, but slowly they are migrating to where they do communicate with each other.

Q. So if today, if I'm a registered pharmacist and I fill a prescription today, and I put it in the system, and as of December 31 it hasn't been picked up, I can go back and access my data from November 14 and delete something?

A. Typically, it is seven days or so. I don't know what -- I mean, you would have to talk more to a pharmacist or to compliance to know more about what is happening in the pharmacies, but the practice is not typically that you keep it -- would keep it that long.

Q. Do pharmacies or do dispensers have to report the number of prescriptions they fill per day?

A. No. We would be able to tell that by how many prescriptions they sent us.

Q. What if any reporting does a dispenser have to give that is different from

the list of 11 things we just discussed with respect to the prescriber?

A. They are basically the same.

Q. Do they have to report how the patient paid for the prescription?

A. They do.

Q. And you said they do not have to report the time or date when a prescription is picked up; is that correct?

A. Not when it's -- so they report what they call a date filled. It is not necessarily the date it is picked up. I believe you previously asked about who picked it up. They are not required to report who picked it up.

Q. The patient information that is reported into OARRS, is that the race of the patient?

A. No.

Q. Is the age of the patient reported?

A. The date of birth, so the age can be calculated.

MS. BROWNE: Can you mute your line, whoever is on the phone, please.

Q. Other than the date of birth, is

the gender of the patient reported?

A. Yes.

Q. And the date of birth and gender of the patient, the requirement that those be reported, that's always been the case?

A. Yes.

Q. What about the medical history of a patient, is that reported through OARRS?

A. No.

Q. Does the system capture overlapping prescriptions from multiple prescribers?

A. So assuming each prescription is a controlled substance, each prescription would be reported. So if we looked for it, we would be able to tell whether two prescriptions overlapped.

Q. And that's the same data that you would use to identify, for example, a doctor shopper?

A. Correct.

Q. We talked about data that identifies the transaction history of a particular OARRS accountholder.

How long does this information that is reported by prescribers and dispensers, how

long is that available?

A. That's changed over time. The law originally allowed us to keep the data for two years. It was later changed to three years. The current statute says that we shall make five years of information available to the -- to OARRS users, and so we shall keep five years.

It allows us, for the purpose of monitoring public health, to keep the data indefinitely though.

Q. So you are required to have the data available to OARRS users as far as back as five years, but in reality, the data exists for a much longer time?

A. We only keep five years available to the endusers. It is set at five years.

Q. And for OARRS purposes, is it kept longer?

A. It can be kept longer for OARRS purposes.

Q. And is it kept longer?

A. Yes.

Q. How far back does the patient and dispenser and prescriber data we have just been

discussing exist?

A. So in an identified manner, it goes back to 2014, because that's when the statute changed from three years.

Q. And what do you mean by "identified"?

A. Where we can identify who the patient is.

Q. And does it exist further back, where it is anonymized?

A. Anonymized data exists back to -- technical to 2007. Some of that data is not real clean.

Q. Where does the identified data through 2014 reside?

A. Both in the clouds, in the production system, as well as at the board of pharmacy.

Q. And where does the anonymized data reside?

A. At the board of pharmacy.

Q. And if you wanted to run a search on a particular patient, is it possible that you could run the data back to 2007?

A. Not likely. There may be ways that

we could, on certain patients who have been very consistent since then, there might be some ways we could figure out something, but not likely.

Q. Is there other information that OARRS collects that we haven't just discussed?

A. Not that -- not that we collect from -- by statute or on a regular basis, no.

Q. Right. So I should be clearer. Is there other information that OARRS is required to collect that we haven't already discussed?

A. No.

Q. And the reporting requirements that we have just discussed, those are all established by state law?

A. Generally by state law, and more specifically in rule.

Q. Do you know why that is?

A. Why it is?

Q. That the reporting requirements -- that there are reporting requirements?

A. To provide some consistency.

Q. Consistency in what?

A. Well, if they weren't a statute,

and the board of pharmacy could change them however often they wanted, it wouldn't be very fair.

Q. You mentioned, when we were talking about dispenser information, the concept of diversion. Do you remember saying that?

A. I may have.

Q. What is your understanding of diversion, in respect to pharmaceuticals?

A. Any use of a drug that -- beyond what it was intended.

Q. And is OARRS capable of running reports that identify diversion?

A. Some types of diversion, not all.

Q. What types of diversion can OARRS run reports about?

A. Well, we have discussed a number of them. Doctor shopping would be one, just overutilization.

Q. Anything else?

A. No.

Q. And we talked about dispensers having a daily reporting requirement, correct?

A. Correct.

Q. How long has that been the case?

A. That also has changed a number of times. I don't remember when we went to daily.

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(Thereupon, Deposition Exhibit 4, Ohio Prescription Drug Monitoring Program, Effective 2017, was marked for purposes of identification.)

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Q. I'm going to show you what we have marked as Exhibit 4. This is the Ohio Prescription Drug Monitoring Program, Effective 2017; do you see that?

A. Yes.

Q. Are you familiar with this document?

A. Yes.

Q. It came off the -- we got this from your website.

A. Uh-huh.

Q. Can you turn to page five for me.

A. Yes.

Q. And at the top of page 5, under Reporting Requirements, it notes, "Effective March 15, 2017, the Ohio PMP will begin requiring pharmacies and dispensers to report

reportable drug dispensations to the SOBP via the PMP clearinghouse"; did I read that correctly?

A. Yes.

Q. It further says, "Dispensations must be reported no later than 24 hours, after dispensing the prescription, although they may be submitted more frequently"; did I read that correctly?

A. Yes.

Q. SOBP is the board of pharmacy, correct?

A. Correct.

Q. What would be an occasion, if you know, where dispensations would be reported more frequently than every 24 hours?

A. There are systems that are in use in other states that require more frequent reporting, and so if such a system, if it is easier for them to report more than once a day, then we would certainly allow it.

Q. So based on this paragraph, at least, it is your understanding, is it not, that as of at least March 2017, there was a daily reporting requirement, correct?

A. Yes.
Q. Is it your understanding, based on this paragraph, that prior to 2017, there was not a daily requirement?
A. So prior to 2017, it would have been weekly.
Q. And was it weekly -- was there a different reporting requirement, other than weekly, at any point in time?
A. When OARRS was first created, it was twice a month.
Q. And for how long was it a twice a month reporting requirement?
A. I believe it was through about 2011, but I don't know that for sure.
Q. Does OARRS monitor compliance with the reporting requirement?
A. Yes.
Q. What are the consequences for dispensers who fail to report in accordance with the requirement?
A. We have not had a large problem with that. So initially, we simply contact the pharmacy to find out, you know, why they are out of compliance. We try to work with the

pharmacy to get into compliance.

Once or twice that hasn't been enough, and we have had to get our compliance, you know, the board of pharmacy's compliance department involved, and every time since then, that has resolved, and we have never really had to take action against them. Nothing more than a pink sheet.

Q. What is a pink sheet?

A. It's basically a reprimand that requires the pharmacy to follow up with how they are going to comply.

Q. Is there a fine associated with that?

A. Not typically.

Q. How is it determined if a dispenser or prescriber fails to report?

A. It would be determined based on, you know, did we receive a report each day from them, as well as are the prescriptions that we receive each day timely, are they -- you know, if you are reporting prescriptions from a month ago, you know, a month late, then that would obviously not be in compliance.

Q. Are reports that indicate

compliance by dispensers and prescribers to OARRS automatically run?

A. They are not. There is -- in the current system, there is a report that one of my staff goes and manually runs, to look at that.

Q. Every day does your staff run that report?

A. No. Typically once a week or so.

Q. Do you know if the state conducts any audits of the reporting compliance?

A. There is no -- nothing outside of what we do in OARRS.

Q. So counties can't run reports to monitor compliance with the reporting requirements?

A. No.

Q. And licensing agencies can't run reports to monitor compliance with reporting requirements?

A. No.

Q. Are there instances where a dispenser is investigated for making too many queries into the database?

A. Not investigated, no. If it is

something that I see or one of my staff sees, they may, you know, may raise awareness, and we may seek explanation, but I've never -- I don't recall any actual investigations into that.

Q. So your office does track how frequently pharmacists or pharmacies access OARRS, correct?

A. We do.

Q. Are there occasions in which pharmacies or pharmacists have been investigated for unlawfully accessing OARRS?

A. There have been a number of investigations into individuals who have used OARRS inappropriately, yes.

Q. And do you know how it is determined that an individual is using OARRS inappropriately?

A. Typically, that is initiated by a complaint from the public, and then it is assigned to an investigator to look into.

Q. Have you been involved ever in an investigation of an unlawful access of OARRS?

A. Just to the extent of providing reports of a request history.

Q. So in addition to being able to

monitor -- well, let me ask you this: Providing reports on a request history, is that the same type of report that you would provide, like we discussed regarding the Summit County Sheriff's Department, so any OARRS accountholder?

A. No. I mean -- so -- okay. Were you asking whether we would provide it to the Summit County Sheriff, or on the --

Q. No. Running a report or being able to identify whether an individual has unlawfully accessed OARRS, how is that determined?

A. It would be any -- it would be any user. It would not just be a certain type of account.

Q. And you are able to monitor any user's access of OARRS, correct?

A. Correct.

Q. And that includes the specific transactions for which they are accessing OARRS, correct?

A. Correct.

Q. The wholesalers are also required to report, correct?

A. Correct.
Q. Is their reporting requirement also daily?
A. No, it's not.
Q. How frequently must the wholesalers report on OARRS?
A. Once a month.
Q. How long has that been the case?
A. Since, I want to say, since about 2011.

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(Thereupon, Deposition Exhibit 5, A Document From the OARRS Database, Entitled Instructions For Reporting Wholesale Transactions to OARRS, was marked for purposes of identification.)

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Q. Exhibit 5 is a document from the OARRS database, entitled Instructions For Reporting Wholesale Transactions to OARRS.
Have you seen this before?
A. Yes.
Q. And what do you understand Exhibit 5 to be?

A. So this is the -- these are the instructions we provide to wholesale distributors on how they can report data to us.

Q. And if you turn to page 3 of Exhibit 5, the page is entitled OARRS Data Submission For Wholesale Transactions; do you see that?

A. Yes.

Q. It notes file format ARCOS; do you see that?

A. Yes.

Q. What is ARCOS?

A. ARCOS is a -- ARCOS is a system that the DEA runs that collects certain wholesale transactions from drug wholesalers.

Q. Do you have an understanding as to the interplay, if any, between ARCOS and OARRS?

A. There is none.

Q. Are you, in your capacity as director of OARRS, able to access ARCOS?

A. I am not.

Q. Did you draft this document, Exhibit 5?

A. I drafted the original document. It has changed a few times since then. I'm not

necessarily the one who made the changes to this final version. I don't remember.

Q. Okay.

A. I certainly approved it.

Q. For example, if you look on page 2 of Exhibit 5, under Method 2: HTTP method.

A. Yes.

Q. Number three of the directions says, "Click the button to locate the properly formatted ARCOS file"; do you see that?

A. Yes.

Q. What does that mean?

A. It would be a text file that is -- that has been created using this ARCOS format that's described on page 3.

Q. And this would be a text file in the possession of the wholesaler?

A. Yes.

Q. And the wholesaler would update this ARCOS file to the OARRS database, if it is complying with the reporting requirements set forth in Exhibit 5?

A. Correct.

Q. If that's the case, then doesn't OARRS have access to wholesalers' ARCOS data?

A. No. In this case, ARCOS is simply -- simply referring to the way the file is formatted. It is not ARCOS. So it is not the data that the DEA houses.

Q. Okay.

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(Thereupon, Deposition Exhibit 6, A Copy of Ohio Code Provision 4729.78, was marked for purposes of identification.)

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Q. Exhibit 6 is a copy of Ohio Code Provision 4729.78; do you see that?

A. Yes.

Q. And it notes that it is effective as of September 29, 2017?

A. Yes.

Q. Is this the code provision that covers the reporting by manufacturers and distributors of, in this case, dangerous drugs?

A. Yes.

Q. And is it your understanding that today, manufacturers and wholesale distributors are both required to report purchaser identification, identification of drug sold,

quantity of drug sold, date and the license number issued by the board?

A. Yes, if they are selling to the entities that are listed elsewhere. I don't remember exactly where they are at.

Q. So a manufacturer only has to report this data if it is distributing to a prescriber or terminal dispenser; is that right?

A. Yes.

Q. Otherwise, this -- these requirements set forth in 4729.78 A, 1 through 5, pertain to the requirements for wholesalers, correct?

A. Correct. It also can be a terminal distributor, if they do wholesale transactions, as permitted under their terminal distributor license.

Q. The date of this, as we said, is effective September 29, 2017; do you see that?

A. Yes.

Q. Prior to September 29, 2017, do you have an understanding as to what the requirements were for wholesale reporting?

A. They were very similar, if not the

same. You know, it must have just been updated in 2017, or maybe renumbered. I'm not sure what happened in 2017, that it would be dated 2017.

Q. When it notes here in 4729.78 A1, "Purchaser identification," what is your understanding of who the purchaser is?

A. It would be either a prescriber or a terminal distributor.

Q. Is the wholesaler required to report the address to which it ships product?

A. Not necessarily. They can report the DEA number, which then we would get the address off of the DEA number.

Q. And it is required to report the quantity of the opioids, correct?

A. Correct.

Q. And is it required to report the frequency?

A. Well, it would be each transaction, so we could determine frequency by that.

Q. We talked earlier today about suspicious orders; do you remember that?

A. Yes.

Q. Are wholesalers required to report

suspicious orders in OARRS?

A. No.

Q. Is OARRS able to run a suspicious order report?

A. We don't have anything in OARRS called a suspicious order report, no.

Q. Is OARRS capable of running a report to identify quantities of opioids that are shipped from a -- beg your pardon, strike that -- the quantity of opioids shipped from a distributor to a dispenser?

A. Yes.

Q. And that's the type of report that has been run, correct?

A. Recently, yes.

Q. And why did you run that report?

A. Because we were -- because we were assisting with the new rule.

Q. Okay. Do you know why the reporting requirement for distributors differs from the reporting requirements for dispensers and prescribers?

A. In what manner?

Q. Well, for example, you mentioned that the requirement for reporting for

wholesalers is monthly, as opposed to the daily reporting for dispensers and prescribers?

A. It was determined -- so originally they were the same. When it was twice a month, both wholesalers and dispensers were required to report twice a month.

When we changed the dispensers to weekly, it was determined that the wholesale information was not -- part of the reason for dispensers reporting as frequently as they do is that it is a healthcare tool, and so, as a prescriber, what was dispensed recently is very important.

The wholesale program is more for monitoring compliance and more of a compliance and law enforcement type of tool, where you are looking more at patterns over time, and so what was done yesterday may not be as -- quite as important as what happened over the last -- the last few months, years, and so forth.

Q. When you say, "It's a law enforcement tool," what do you mean by that?

A. We use it to ensure that -- that the law is being followed. It doesn't have patient information in it, so it is a not a

healthcare tool.

Q. And what part of the law are you watching to make sure it is followed?

A. There is a number of parts. The original purpose of collecting the wholesale information was to determine -- originally prescribers, what prescribers dispensed from their office was not required to be reported to us. And so instead, we were looking at what was being purchased, and that's why only prescribers were -- the sales to prescribers was what was being reported.

Since then, we have added on what we look for since then, to include, you know, what is being purchased, therefore, what should be reported as dispensed. The limits on what a prescriber can personally furnish have been put into law, so we can now see whether a prescriber is purchasing more than they are allowed to dispense. So there has been more utility of it, as time has gone on.

Q. You mentioned that the reporting for wholesalers helps you determine patterns over time?

A. Yes.

Q. What types of patterns?

A. So patterns such as, you know, if a drug is being purchased, you know, in a small quantity every -- you know, every other month would be different than large quantities every month. You know, we can see those types of patterns.

It's not what is -- we are not so much looking -- we're not looking at one individual day, as we are a period of time.

Q. Fair to say you are looking for a suspicious pattern?

A. At times, yes.

Q. What are the consequences for a wholesaler who fails to report as required?

A. It would be very similar to a pharmacy. We would first contact the wholesaler and find out why, and work with the wholesaler to get into compliance.

We all understand that there are -- that things happen, and so, you know, we work with people first.

Q. How is it determined that a -- if a wholesaler is failing to meet the reporting requirements?

A. If we don't receive a report each month.

Q. Is somebody responsible for tracking the various wholesalers and whether a report has been received each month?

A. It's my staff monitors that.

Q. Does OARRS automatically kick out a report to your staff, on a monthly basis, that identifies the wholesalers who have reported or not reported?

A. No. There is nothing automated in the wholesale system, with the exception of the actual data collection.

Q. With respect to the wholesale system, is the state, other than the board of pharmacy, able to conduct any audits of reporting by wholesaler?

A. No.

Q. Is any entity, other than the board of pharmacy, able to conduct audits of the information in OARRS related to the wholesalers?

A. No.

MS. BROWNE: Have we been going an hour again?

THE NOTARY: Pretty close.

MS. DEHNER: Do you want to take a lunch break or --

MS. BROWNE: Well, let's go off the record for a second, if we may, and talk about that.

THE VIDEOGRAPHER: Off the record at 12:17.

(Recess taken.)

THE VIDEOGRAPHER: On the record, 1:09.

Q. Welcome back, Mr. Garner.

Is there a way for the OARRS system to trace an opioid prescription to its specific manufacturer?

A. Yes. The NDC number does tell you who the manufacturer is.

Q. And by the same token, the OARRS can trace an opioid prescription back to a specific distributor, correct?

A. To an extent. If a, say, a pharmacy purchases from multiple distributors, I would not necessarily -- if it is the same NDC that they purchase from multiple distributors, I would not be able to say this

bottle came from distributor A and this one from distributor B.

Q. Can OARRS collate data, daily dispensing information for a particular terminal distributor over time to detect spikes?

A. Yes.

Q. Can OARRS collate daily dispensing information over time to determine who prescribed an opioid?

A. Yes.

Q. Can OARRS collate daily dispensing information to determine to whom a prescription was dispensed on a specific day where there was a spike?

A. Yes.

Q. When we were talking about reports, and they are made by prescribers and -- let me back up.

Individuals who have access to OARRS, and we talked about the fact that pharmacists have accounts but a pharmacy itself does not, right?

A. Correct.

Q. Can a pharmacy, like a corporate

entity, have an OARRS account?

A. No.

Q. What if any restrictions are there on the sharing of data from the OARRS database?

A. The restrictions are that it is for -- so there are specific purposes as to why any user can access OARRS, and it is for that use only, and it is not to be -- so then it would not be distributed outside of that.

Q. So pharmacists -- a particular pharmacist is prohibited from sharing OARRS information with its corporate parent, correct?

A. Correct.

Q. And is data or information requested by, for example, the Summit County Sheriff's Department, is that restricted in any way from dissemination?

A. It is to be used in the case that it was -- you know, that it was requested for. So if, you know, if there are others working the case, you know, it is to stay within the case.

Q. So, for example, the Summit County Sheriff's Department could not obtain a report from OARRS and share it with an attorney?

A. If it is their attorney that is working on the same case, then, yes, technically they probably could.

Q. If the attorney represented the county in an action against retailers, distributors and manufacturers of opioids, could the Summit County Sheriffs's Department share report information with that lawyer?

A. I'm not sure. I would have to review the law, and I'm not an attorney, so...

Q. Okay. Have there ever been occasions when a law enforcement entity has requested a report and OARRS has declined to provide that information?

A. There have been, there have been times, yes. Typically not through the normal -- the normal course of the way we do things. I mean, we design OARRS and the web forms such that we get the information that we need and -- you know, and those requests are appropriate.

Typically it would be a request that comes, you know, by email or a phone call, or something like that, that we would have to deny, but, yes.

Q. Can you think of a specific occasion when a request has been denied?

A. We have had --

MR. FARRELL: Objection. You are going off the topic here. Limitations under 16 do not entail any of the specific actions taken by the board of pharmacy at the request of law enforcement or directed toward any of the registries.

Q. You can answer. Did you need me to repeat the question?

A. No. I'm thinking.

We have been requested for, say, top so many prescribers of a specific drug, and that would be one that we would not honor that type of a request.

Q. Do you know if a request for the top prescribers of a specific drug has been made recently?

A. Not that I can recall. It's been a while.

Q. We talked a little bit before the break about suspicious order reports. Do you know if OARRS has been used to run suspicious reports?

A. I'm not sure how that would make sense. I mean, only -- suspicious order reports come from, my understanding is, suspicious order reports come from wholesale distributors, and they don't have access to OARRS, so...

Q. Is there a database available to the BOP, other than OARRS, that would -- that provides information about suspicious orders?

A. Not to my knowledge.

Q. You mentioned, when we were talking about how long data had been retained, that there is data back to 2007 that is anonymized?

A. Yes.

Q. Is any of the data back to 2007 that is still available pharmacy or wholesaler specific?

A. Only the patient on prescription data has been anonymized. The prescriber and pharmacy is still available. Nothing on the wholesale side has been anonymized. It is available, everything we have received back to 2006.

Q. Can you describe for me the process by which the outpatient data is transmitted

from a dispenser or prescriber to OARRS, and what I mean by that is, what does the screen look like when they get on, how does it work?

A. Much like with the wholesale distributors, there are multiple methods of submitting data. The most common, much like wholesalers can submit using the ARCOS file format, dispensers can report using the ASAP file format.

So this is a rather complex file format that collects all of the fields that are required and typically is done automatically by their software. It's typically not something that they have to do manually. Each day it just -- it runs and sends it to us automatically.

Some of them do have a slight manual process, that they have to click a button or two, maybe give a date range, but it's not, you know, hand keying in all of that information.

For a small pharmacy that dispenses very little or a prescriber who dispenses from their office, there is also a web form that basically looks -- you know, it is just a form

with boxes for each of the required fields that they can type into for a single prescription and submit. So that's a secondary option.

Q. So we talked about this a little bit. There is a difference between a point-of-sale side on the pharmacy, as to whether a prescription is actually picked up, versus when it is filled, correct?

A. Correct.

Q. And if I understand your testimony, the information about prescriptions, as they are being filled, is automatically updated, such that, for example, at the end of the day, a pharmacist just has to press a few buttons, as opposed to manually entering every single prescription from that day?

A. Typically.

Q. And when it is not typical, or the atypical occasion is the very small pharmacy; is that right?

A. Correct.

Q. An independent, a small independent pharmacy?

A. Correct, or maybe not even a full-scale pharmacy. Maybe ones that, you

know -- that only does noncontrolled substances. So the only prescriptions that they are entering are the gabapentin prescriptions, or something like that, but they really don't have a lot to report.

Q. Is it the same for the wholesalers' data report? In other words, do the wholesalers have to manually enter that information, moving that ARCOS file that we talked about from, I think it was, Exhibit 5?

A. I'm not as familiar with wholesaler software, so I don't know the answer to that.

Q. Who would know the answer to that?

A. The wholesaler distributors.

Q. And while we are talking about user interface, if I'm the sheriff of Summit County and I want to make a request for a report, what does that screen look like when I get on?

A. That particular screen would have a place for you to enter -- well, again, there are two different screens, depending on whether you are asking for a patient or a prescriber.

But for a patient, it would have boxes for their name, their date of birth, their address and zip code and phone number,

and a date range for the report, and the case number.

Q. So we have talked about the entities that are required to report, and they have specific user account numbers, correct?

A. The entities that are required to report?

Q. Correct.

A. Yes.

Q. And we have talked a little bit, by way of example, of the sheriff of Summit County. Does the sheriff of Summit County have one user account number?

A. That individual person, yes. Their office would have one for each individual person who has access to OARRS.

Q. So that could be a detective within the sheriff's department?

A. Yes.

Q. Could it be an administrative assistant in the sheriff's department?

A. Typically, no. I don't believe I've ever -- I don't even know that I've ever seen a request for an account for an administrative assistant. I'm fairly certain I

haven't approved one.

Q. Is there a limit to how many accounts a particular entity can have, or account numbers?

A. No.

Q. Entities such as the various departments of the DOJ, for example, DEA, we talked about, has an OARRS account, correct?

A. Some of their -- some of their investigators have them.

Q. I'm sorry to interrupt you. Was there something else you wanted to say?

A. No.

Q. Is there a limit to the number of accounts that can be assigned to the DEA?

A. No.

Q. Who makes the decision as to the appropriate number of accounts to be assigned to any entity that can access OARRS?

A. We don't look at it in terms of the numbers of accounts. I have never even thought of it that way.

Q. How do you look at it?

A. About whether or not an individual should have access to OARRS, based on statute.

Q. You are responsible for assigning accounts to users of OARRS; is that right?

A. Yes.

Q. And when you say that you make a determination based on whether or not that individual should have access, what information do you collect about a particular individual, to determine whether or not it is appropriate for the individual to have access?

A. It depends on the type of account. So for law enforcement, we collect the -- we get information about the agency. We get the agency head to send us a letter, indicating who they approved to be supervisors, and then those supervisors each have to approve the individual investigators that work under them, who they will be responsible for.

But we then collect information identifying each individual and, depending on the account type, you know, whatever credentials would be appropriate for that.

Q. So the account is individual specific, correct?

A. Correct.

Q. And if a new detective joins the

agency, the DEA, and I'm a DEA agent and I have an account number, I can't let the new detective use my account; is that correct?

A. That's correct.

Q. What, if any, penalty is there if I share my account number with another detective in the agency?

A. It is in statute. I don't recall exactly what it is.

Q. But there is some statute that provides for a penalty?

A. Yes.

Q. We talked about your ability to access, for example, the sheriff of Summit County's transaction history; do you recall that?

A. Yes.

Q. Can you search by a particular user, within the sheriff of Summit County, to find out that individual's transaction history?

A. Yes.

Q. And is that true, for example, of the DEA?

A. Yes.

Q. So you could track the transaction

history of any individual account number within OARRS?

A. Yes.

Q. We talked just a minute ago, a little bit, about the registration process for an account. Does it differ, depending on whether you are prescriber or a dispenser or enforcement?

A. Yes.

Q. How does that differ?

A. For a prescriber or dispenser, we don't have the process of approving the agency and the agency head with the supervisors. There is not all of that structure to it.

For a prescriber, we collect, again, their personal identifying information, their name, date of birth, their driver's license number, address, all of that kind of information, but also their professional license numbers and DEA numbers, and we verify that information prior to issuing an account.

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(Thereupon, Deposition Exhibit 7, A Document From the OARRS Website, Dated November 24, 2015 Entitled

Mandatory OARRS Registration and Requests, was marked for purposes of identification.)

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Q. I'm going to show you what we are marking as Exhibit 7. This is a document from the OARRS website, dated November 24, 2015, entitled Mandatory OARRS Registration and Requests; do you see that?

A. Yes.

Q. Have you seen this document before?

A. Yes.

Q. And this document is -- well, why don't you tell me, what is this document?

A. This is a document that was created by the board of pharmacy as a -- as a helpful tool for prescribers, because there was some confusion.

You know, the law is broken into many different areas, so it was kind of an educational document that was created.

Q. And Exhibit 7 pertains to prescribers and their delegates and pharmacists and their delegates; do you see that?

A. Yes.

Q. This document does not address the registration of wholesalers, does it?

A. It does not.

Q. Is there a separate document that discuss how -- what the process is for wholesalers to register?

A. Wholesalers would not register for it. So this is for registering for an account on the prescription side of OARRS to access the data. This is not the same type of information for submitting data. It is not for that type of account. Also, it is not at all for the wholesale side of OARRS.

Q. Can a prescriber with an OARRS account access the data of any patient?

A. Legally, they can only access their own patients.

Q. But as a practical matter, they could access any individual's information; is that correct?

A. Technically speaking, there is nothing in the system that actively blocks them from accessing somebody who is not their patient.

Q. Same question with respect to

prescribers. Can prescribers access data for any patient?

A. That was actually the same question you just asked. Did you mean something different?

Q. I'm sorry. Thank you for the correction.

A. Dispensers?

Q. Can dispensers access information for any patient?

A. Yes. It is the same.

Q. Manufacturers cannot register to use OARRS; is that right?

A. That is correct.

Q. We talked a little bit about this, but not specifically. Is the nature of the access limited by the type of user account?

A. Yes.

Q. Are there names for the specific types of user accounts?

A. There are. There are also three different systems that you may have an account for.

Q. What do you mean by that, three different systems for which you can have an

account?

A. So Exhibit 7 that you gave me, refers to access to the AWARxE platform. So that is where a prescriber, a dispenser, a law enforcement agent would go to request the data from OARRS.

A dispenser may also register for access to a system called Clearinghouse. That is where they submit prescription data. A wholesaler distributor can access -- can apply for an account to the wholesale system, to submit data through the wholesale system.

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(Thereupon, Deposition Exhibit 8, PMP AWARxE User Support Manual, was marked for purposes of identification.)

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Q. Exhibit 8 is a copy of the PMP AWARxE User Support Manual; do you see that?

A. Yes.

Q. Are you familiar with this document?

A. Yes.

Q. At the top of page 5, under What is

a Requester, it reads, "A requestor is a PMP AWARxE account type that is typically used to review a patient's prescription history. A requestor's primary task within the application is to determine if a patient should be given or dispensed a prescription based on their prescription history. Requesters are the strongest line of defense to prevent prescription drug abuse." Did I read that correctly?

A. Yes.

Q. And it goes on to note that, "Physicians and pharmacists are the most common type of requester," correct?

A. Correct.

Q. But, "There are myriad of roles that can be classified as a requester, including those of law enforcement," correct?

A. Correct.

Q. So and then it goes on to list these types of entities, and those are all examples of requesters; is that right?

A. That is correct.

Q. And that's includes the Medicaid program, right?

A. Yes.
Q. It includes Workers' Compensation?
A. Correct.
Q. Benefit plan managers are requesters in the AWARxE system?
A. So, unfortunately, the system does not allow me to customize the names of roles. There are a number of these that I might change, otherwise. Benefit plan manager we use for the Medicaid and BWC managed care organizations.
Q. It also notes that corrections and probation, under law enforcement, are requesters; do you see that?
A. That's correct. All law enforcement accounts -- and again this is one that I would rename and just call it law enforcement, rather than corrections, but corrections is the name that is in the system.
Q. Does the department of corrections have access, as a requester, to the OARRS database?
A. No.
Q. Does the department of corrections have any access to the OARRS database?

A. No.
Q. What about the office of parole and probation, or maybe here it's just probation, does the office of probation have any access to the OARRS database?
A. Probation officers, if they oversee drug crime cases, may have access.
Q. And they would have access, as a requester?
A. Yes.
Q. So dispensers have a requester account, but they also -- is the account that is hooked to the Clearinghouse separate from this PMP AWARxE account?
A. Yes.
Q. Are there different account numbers between the two?
A. Yes.
Q. You mentioned that -- it identifies, in this list under healthcare professionals, nurse practitioners/clinical nurse specialists, back on page 5 of Exhibit 8, under What is a Requester; are you with me?
A. Yes.
Q. Can nurse practitioners get

requester accounts?

A. If the -- yes.

Q. "If the" what?

A. If they have prescriptive authority, which they all do now.

Q. What about physicians assistants, can they have access?

A. Yes.

Q. Do they have separate account numbers or -- do they have separate account numbers?

A. Yes.

Q. What if any role do you understand a requester to have in preventing any prescription drug abuse?

A. Any prescriber role -- I mean, obviously the prescriber is where a prescription initiates, and so they get to determine whether or not they write a prescription. So that clearly is a place where the prescription can stop.

Same with the dispenser. A dispenser, you know, is sort of the last line in that process, and so can also stop a prescription from being dispensed.

So, clearly, those are key points that play a big role there. And then the others are more after the fact, that can apply outside influence.

Q. Such as?

A. The law enforcement officer, obviously, can take action against the patient or against the prescriber, if a law is broken.

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(Thereupon, Deposition Exhibit 9, A 2017 Article Entitled Opioid Prescriptions By Specialty in Ohio, 2010 to 2014, was marked for purposes of identification.)

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Q. I'm going to show you what has been marked as Exhibit 9. Exhibit 9 is the copy of a 2017 article, entitled Opioid Prescriptions By Specialty in Ohio, 2010 to 2014, and it was printed in 2017 in the American Academy of Pain Medicine; do you see that?

A. Yes.

Q. You are identified as an author of this article; is that correct?

A. That's correct.

Q. What if any contribution did you make to the article that is Exhibit 10?

A. I provided the identified data for research, and I was -- I was a key resource in understanding the data and what certain things might mean or not mean. I also did a certain amount of editing.

Q. How did you come to be involved in the writing of this article that is Exhibit 10?

A. Dr. Weiner approached me, wanting to do some research, provided a valid research protocol with IRB approval, and signed an MOU with our agency to have access to deidentified information.

Q. And MOU is memorandum of understanding?

A. Yes.

Q. How do you know Dr. Weiner?

A. I've met him at a number of different conferences and meetings. I'm not sure which one was first.

Q. I would like to direct your attention to the Introduction, which is the bottom of the rightmost column, on page 978 on Exhibit 10, which is the first page of Exhibit

10.

A. Uh-huh.

Q. You and your co-authors write, "There were multiple causes of increased prescribing, including a heightened focus on assessment and treatment of pain," open paren, "e.g., the Joint Commission's pain initiative," closed parens, "aggressive and possible fraudulent marketing by pharmaceutical companies, desire for providers and institutions to score highly on patient satisfaction scores, a small number of providers and pharmacies that prescribed and dispensed massive quantities of prescriptions for profit in an unprofessional and sometimes criminal fashion," open parens, "pill mills," closed parens, "and a cultural shift that fostered unreasonable expectations of pain relief." Did I read that correctly?

A. Yes.

Q. Do you agree with this statement?

A. I don't have firsthand knowledge of a lot of it, as I'm not a prescriber. Dr. Weiner is.

I have certainly read plenty of

news, heard plenty of stories about it from prescribers. So my assumption is that it's true, but I don't have firsthand knowledge.

Q. In your role as the director of OARRS, is this statement consistent with your experience, the statement I just read into the record from your article?

A. I don't know that these would be things that I would be directly affected by, as the director of OARRS. Most of these are things that a physician or a pharmacist would be subjected to.

Q. There is no mention of wholesale distributors in this statement that I just read into the record, is there?

A. I don't see it.

MS. BROWNE: I apologize, that was Exhibit 9. Sorry.

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(Thereupon, Deposition Exhibit 10, An Article Entitled Prescription Opioids and Labor Market Pains, Dated March 28, 2018, was marked for purposes of identification.)

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Q. I'm going to mark as Exhibit 10 an article that's entitled Prescription Opioids and Labor Market Pains. This is dated March 28, 2018, various authors, and it is out of the University of Tennessee.

Have you seen this article before?

A. I don't believe so.

Q. If you turn to page 9 of Exhibit 10, at the bottom of the page, under the heading Data; are you with me?

A. Yes.

Q. It reads, "County-level data on opioid prescriptions were acquired directly from ten U.S. states, Arkansas, California, Colorado, Florida, Massachusetts, Michigan, Ohio, Oregon, Tennessee and Texas, by requests through their respective controlled substance monitoring database, CSMB, or PDMP database;" did I read that correctly?

A. Yes.

Q. Do you recall providing access to OARRS to any one of the authors of Exhibit 10?

A. I don't, but if they are looking at the basic numbers of prescription by county, again, as I mentioned earlier in my testimony,

we do have a spreadsheet on our website that they may have used.

Q. Do you recall ever being contacted by any of the authors of Exhibit 10?

A. None of the names ring a bell to me, so, no.

Q. Is there a requirement that an Ohio prescriber review or access OARRS patient data from time to time?

A. Under certain circumstances, yes.

Q. What are those circumstances?

A. Prior to issuing a prescription for any opioid or benzodiazepine, and every 90 days thereafter, with a certain set of exceptions, and then any time a prescriber continues a course of treatment involving any controlled substance for more than 12 weeks.

Q. And is that codified somewhere?

A. The "prior to an opioid or benzodiazepine, the 90 days thereafter," is codified in each profession's section of the Ohio Revised Code. The 12 weeks is in each profession's section of the Ohio Administrative Code.

Q. The every 90-days requirement

that's in the specific profession's code --

A. Yes.

Q. -- do you know how long that has been in place?

A. That would have been House Bill 341, which passed in 15 or 16, I believe.

Q. And the requirement under the Ohio Revised Code about the every 12 weeks, do you know how long that's been in effect?

A. So that was the result of the House Bill 93 that we discussed earlier. Of course, after the actual bill passed, there was a period of time to write the rules, so sometime after the end of 2011.

Q. Have those requirements been updated at all, so the revised -- the Ohio Revised Code since 2011?

A. That's the Ohio Administrative Code.

Q. I'm sorry.

A. That was 2011. It was updated at the same time that the new statute Ohio Revised Code was put in place, at least I know the medical board's was, I don't know about the other boards, but they updated it to reflect

what was in the Ohio Revised Code, as well as continued to keep what was in the Ohio Administrative Code, and to kind of clarify the differences between the two, so it wasn't quite so confusing.

Q. And that was separate from the house bill, the 341?

A. House Bill 341 is what put the requirements into the Ohio Revised Code.

Q. Okay. And since that -- and that was 2015, 16, correct?

A. I believe so.

Q. And since that time, has it been updated?

A. No.

Q. We talked before the break about a dispenser's ability to delete a prescription that hadn't been picked up; do you remember that?

A. Yes.

Q. Once a distributor or wholesaler submits the information that it is required to submit, can a distributor go back and review any of that information or change it?

A. The only way to change it would be

to submit a new record with a negative quantity, to basically negate what was previously reported.

Q. Once a distributor submits the required information, who does have access to it?

A. My staff.

Q. Do any of those agencies we talked about that are mandated by state and are permitted to have OARRS account numbers, are any of those agencies or entities permitted access to the wholesaler's side of OARRS?

A. No, they are not.

Q. Can any distributor see what another distributor reported in OARRS?

A. No.

Q. So you and your staff are the only individuals who have access to the wholesale side of the OARRS database?

A. Correct.

Q. But to be clear, a distributor or the general public does have access to the quantity of opioids shipped or sold in a given year in various counties in Ohio?

A. That information all comes from the

dispensing side, the prescription side. It does not come from wholesale.

Q. But is that public, information about the quantity of opioids shipped or sold in a given year?

A. Not from OARRS, no.

Q. Is it available publicly otherwise, that you know of?

A. The only other source of that information I'm aware of would be the ARCOS system that DEA has. So they may make some of that public. I have no idea.

Q. Can a pharmacist -- I think we talked about this, but a pharmacist can search OARRS by patient name, correct?

A. Correct.

Q. Can they search by prescription name?

A. No.

Q. Can a pharmacist search by pharmacy name?

A. No.

Q. Can it search by distributor name?

A. No.

Q. Can it search by a manufacturer

name?

A. No.

Q. How frequent, if there is such a limitation, can a particular pharmacist run report requests in OARRS?

A. As frequently as they have a patient in front of them.

Q. Can they set up patient alerts?

A. No.

Q. Will OARRS red flag any -- an order that it sees or -- a prescription that it sees as suspicious, as a dispenser is inputting the information or a prescriber?

A. No.

Q. Is there a reason that there isn't the capability of, I'm going to call it a red flag, to be raised when a specific patient is -- a specific patient name is entered into OARRS, as someone who is being prescribed or dispensed an opioid?

A. So when you are saying a patient name is entered, I was assuming you meant as they were entering a prescription. If they are making a request, if enough information is provided to them, they see the list of

prescriptions they have, the NarxCare information.

It is up to their professional judgment to determine whether or not any of that information deems a different course of action.

Q. And the data on a particular patient that can be accessed by a prescriber or dispenser is the data that is available back to 2014?

A. Yes, and the rolling five years, once we get there.

Q. We talked a little bit about this. The medical examiners, or the coroners, have access to OARRS data; is that right?

A. Yes.

Q. And the coroner's have requester-level access to OARRS data?

A. Yes.

Q. Do coroners request reports from you?

A. The coroner would request a report, just like a prescriber or pharmacy would -- I'm sorry, a pharmacist.

Q. Have you received requests for

information on overdose deaths?

A. What type of --

Q. Sure. So if the coroner is doing a medical exam of a deceased individual and suspects an overdose, can they request information from OARRS about that patient -- well, about that patient?

A. Yes. That is what the law permits them to have access to OARRS for.

Q. And they don't need to contact you for that report data, they can pull that up themselves?

A. Right. Just like a prescriber or a pharmacist would, they have their own credentials to log into the OARRS system to pull that.

Q. So unlike the system with law enforcement, where they make a request and a supervisor approves it and then you make a determination as to whether the law enforcement can get a report, coroner's have direct access; is that right?

A. That is correct.

Q. Can you pull for me from your pile Exhibit 3, please, which was the November 21,

2011 House Bill 93 report from Dr. Winsley?

A. Yes.

Q. If you turn to page 7 of that report, under Enhanced Drug Utilization Review, it reads, "The question has been raised whether OARRS can evaluate the patient data and" quote, "red flag," end quote, "certain patients so that healthcare providers can be alerted to a potential doctor shopper. This is not an appropriate use of OARRS for the following reasons;" did I read that correctly?

A. Yes.

Q. The first reason is, "There is no unique identifier for patients." Is that still the case?

A. It is.

Q. But patient's name and patient date of birth are entered in the system, correct?

A. Correct.

Q. And those are not determined to be unique identifiers?

A. No, they are not.

Q. What would you consider to be a unique identifier?

A. Social Security Number or driver's

license number.

Q. Does OARRS have the capability to receive unique identifier information?

A. Yes.

Q. The other reason that's noted that OARRS does not evaluate patient data and red flag certain patients is that it does not have sufficient information to make such an evaluation. Do you have an understanding as to why that is?

A. At the time this was written, there was no diagnosis information in OARRS. Additionally, even today, we would not have all of the history that a healthcare professional would have about their case to know, you know, what other diagnoses the patient may have, what other circumstances there may be.

We are really dealing just with a list of prescriptions, which is not the entire picture.

Q. But OARRS, you do run reports on potential doctor shoppers?

A. We do.

Q. The next reason is, "Data entry errors at the pharmacy;" did I read that

correctly?

A. Yes.

Q. Is that still a problem in OARRS?

A. It can be. This particular section was dealing with a suggestion that OARRS should identify these red-flag patients and automatically send information to a prescriber.

In a system, you know, most pharmacy systems, a pharmacist selects the prescriber by name. Clearly, there are prescribers in Ohio that have the same name, and so sometimes they pick the wrong one or pick the one right next to them or a similar name or something, that sometimes the wrong prescriber is on a prescription.

The last thing we would want to do is send patient information to somebody who shouldn't have it.

Q. But OARRS, thanks to your code writing now, has the ability to cross-reference the prescriber with the dispenser; doesn't it?

A. So we have always known both the prescriber and the dispenser.

Q. But doesn't that reduce if not eliminate the error of a data entry, if the

wrong prescriber is listed?

A. No, not at all.

Q. Why not?

A. I don't understand how it would. If the dispenser puts the wrong prescriber on the data, how would knowing who the dispenser is change that?

Q. Don't you have the information from the prescriber side?

A. No. It is all -- everything comes from the dispenser. So if the prescriber is the dispenser, then it all came from the prescriber, but everything comes from whoever dispensed the drug.

Q. All right. The last point is that, "Evaluation of data was never intended to be a function of OARRS." That's no longer the case, is it?

A. It is not. Clearly we do a lot more valuation of data than we did then.

Q. On page 8, under Systematic Monitoring For Misuse or Diversion of Controlled Substances, it reads, "Current law requires the board to conduct surveillance on the database to detect potential violations of

law and refer suspicions to appropriate law enforcement agencies or health professional licensing boards for investigation." Did I read that correctly?

A. Yes.

Q. That continues to be a role of you and your staff at OARRS, correct?

A. Correct.

Q. And if you turn to page 10, the last paragraph before Conclusion reads, "OARRS provides quarterly reports to Ohio Department of Alcohol and Drug Abuse Services with county-level data. Each county's alcohol, drug abuse, and mental health board, or equivalent, receives the same data for that county for the most recent eight quarters, which allows counties to determine some of the trends for patients in their respective county." Did I read that correctly?

A. Yes.

Q. How long have these quarterly reports been provided?

A. They no longer are. That is what is now the county data report that is on the public website. Basically, each county only

received their own portion of that, at that time. We decided that there really was no reason to, basically, hide other counties from each county. We just went ahead and put it on the website.

Q. Have you ever received requests from a specific county for a specific type of report?

A. We have.

Q. In what circumstances?

A. Counties, you know, that don't -- that don't know the legalities of how OARRS is used often request information that we can't provide. So, I mean, it's -- there is nothing besides this that we would be able to provide.

Q. When was the last time you received a request from a county for a report?

A. Within the last few months. I don't know. I mean, I get them periodically, so...

Q. Do you recall who made the request?

MR. FARRELL: I'm going to object. The scope of this is going beyond the 30(b)(6), and when we start delving --

MS. BROWNE: You can say that you have an objection, but we don't need to hear the speaking.

MR. FARRELL: Well, I think you do. I think this goes directly toward what this witness for -- my speaking objection is that there is a room full of lawyers that have prepared for this deposition on a specific subject matter, and if we are going to go into the other subject matter, I would at least like to reserve the right to come and revisit those, since this is a 30(b)(6) corporate designee.

Q. What county was the one that most recently requested data from you?

A. I don't recall.

Q. And do you recall the nature of the request?

A. No, not specifically.

Q. You mentioned, I think, that licensing boards have access to OARRS; is that right?

A. Their investigators do, yes.

Q. Must an investigation already be underway for a licensing board to have access to data?

A. Yes.

Q. And the investigators request data in the same way that, for example, the sheriff's department requests data, correct?

A. Correct. We actually treat them just like law enforcement.

Q. Is OARRS able to produce a report as to an individual who should be investigated?

A. The system itself doesn't. That would be what some of the various analyses that we discussed this morning goes to.

Q. Do you run reports on doctors who have prescribed opioids to a patient who has died by overdose?

A. We have.

Q. Do you do that routinely?

A. I don't know, routinely, who died of an overdose. I don't have that information until well after the fact.

Q. In what circumstances have you run reports on doctors whose -- to whom they have -- strike that.

In what circumstances have you run a report on a doctor who prescribed opioids to a patient who died of an overdose?

A. After all the data has been vetted and finalized, I get a list from the department of health of who, for a given year, has died of an overdose, and so we look at those kind of as a -- en masse, and so we then would look possibly at a prescriber who had multiple patients, typically, die of an overdose.

Q. And then what would you do with that information?

A. Provide it to our compliance department.

Q. To what end; do you know?

What does the compliance department do with that information?

A. It depends.

Q. On what?

A. On what they -- on what they determine from the information that we give them. There would have to be a determination as to what the next step would be.

Q. Ohio drug court programs have access to OARRS; is that right?

A. Correct.

Q. Since when have Ohio drug courts had access to OARRS?

A. That's fairly recent. I believe it was 2017.

Q. Why do they have access to OARRS?

A. To monitor the individuals who are in their drug court program.

Q. Do drug courts have requester accounts?

A. Yes.

Q. So they are not restricted as to the identity of individuals for whom they can run reports; is that correct?

A. Not in a technical manner, no.

Q. Do you know who Thomas Gilson is?

A. I do.

Q. Who is he?

A. He's the medical examiner for Cuyahoga County.

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(Thereupon, Deposition Exhibit 11, A Presentation By Dr. Gilson, Entitled Overdose Deaths in Cuyahoga County, was marked for purposes of identification.)

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Q. We will mark as Exhibit 11 a

presentation by Dr. Gilson. It is entitled Overdose Deaths in Cuyahoga County.

Have you seen this document before?

A. I may have. I saw a presentation that he gave earlier this year. I don't know if this was the same one or not.

Q. If you turn to the sixth page of this document, Exhibit 11, it says PDR Findings at the top of the page. Are you with me?

A. Yes.

Q. Do you know what PDR stands for?

A. I do not.

Q. Have you heard of the Poison Death Review Committee?

A. I'm not familiar with it, no.

Q. If you turn to, it's the eighth page of what I have given you, and it is entitled PDR Findings, and it is the one that starts with "73 percent of heroin overdose"; are you with me?

A. Yes.

Q. It says, "73 percent of heroin overdose victims had a file with the Ohio Rx Registry System, OARRS"; do you see that?

A. Yes.

Q. Do you know how Dr. Gilson has that information?

A. Well, these were the decedents that he -- that he investigated in his office, and, therefore, he would have been permitted to access OARRS for those individuals, and so I'm sure that he and his staff made these observations.

Q. On the next page of the document, in red, it reads, "A high percentage of fatal overdose victims are receiving legal prescriptions for narcotics in spite of a state drug monitoring program"; did I read that correctly?

A. Yes.

Q. Have you had conversations with Dr. Gilson about expanding the use of the OARRS system?

A. I've had a number of conversations with Dr. Gilson. I don't recall any of them being about expanding the use of OARRS.

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(Thereupon, Deposition Exhibit 12, A Document Dated August 9, 2017, Entitled Building Dynamic and

Functional Interagency Cooperation, Authored by Barbara Sears, Director, Ohio Department of Medicaid, was marked for purposes of identification.)

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Q. I'm going to mark as Exhibit 12 a document dated August 9, 2017. It is entitled Building Dynamic and Functional Interagency Cooperation, authored by Barbara Sears, Director, Ohio Department of Medicaid; do you see that?

A. I do.

Q. Have you seen this document before?

A. I don't believe so.

Q. If you turn to page 5, it is actually the third page of the document so -- and the title of this slide is Ohio Automated Rx Reporting System, OARRS, Data, Number of Doctor Shoppers By Year; do you see that?

A. I do.

Q. And we've discussed that the Ohio Department of Medicaid has access to the OARRS database, correct?

A. They have access to make a request

of individual patients that are Medicaid recipients.

Q. So as a requester?

A. Yes.

Q. So although they are authorized to search for any patient who is a Medicaid recipient, theoretically, they could search the name of any patient, correct?

A. Technically speaking, yes.

Q. And according to this slide produced by Dr. Sears, the number of doctor shoppers has decreased from 2010 to 2015, according to OARRS data; is that right?

A. Yes. She got this directly from our website.

Q. And in this chart, or this slide, it notes that, "A doctor shopper is defined as an individual receiving a prescription from five or more prescribers in one calendar month"; did I read that correctly?

A. Correct.

Q. Is that your understanding of what a doctor shopper is as well?

A. That is our definition, yes.

Q. Do you have an understanding that

Governor Kasich established a Governor's Cabinet Opiate Action Team in 2011?

A. Yes.

Q. GCOAT, I think?

A. Yes.

Q. Is the BOP a member of that team?

A. Yes.

Q. What do you do -- what does BOP do, as a member of the Governor's Cabinet Opiate Action Team?

A. We have played many roles over the years. Obviously, a lot of things have happened since 2011. We have had -- we have provided input, where we have felt our role allowed us to do so.

Q. I'm about to switch topics. Do you want to take a break or keep going?

A. I don't care.

MR. FARRELL: Please, let's take a break.

THE VIDEOGRAPHER: Off the record, 2:12.

(Recess taken.)

THE VIDEOGRAPHER: On the record, 2:20.

Q. Mr. Garner, can you pull out Exhibit 8 for me, please. That's the AWARxE User Support Manual.

A. Okay.

Q. And turn to page 45 for me. Section 9 on page 45 reads Introduction to NarxCare; do you see that?

A. Yes.

Q. What is NarxCare?

A. NarxCare is the -- kind of an add-on to the AWARxE platform that provides additional insight into the prescription data.

Q. When did it become available?

A. It was early this year.

Q. Is that when it was first available in the marketplace, or is that when it was first incorporated into OARRS?

A. Ohio was the first state to incorporate it statewide.

Q. Is it a useful add-on?

A. It is specifically for the healthcare users of OARRS, the physicians and the pharmacists, and we've gotten very positive feedback about it.

Q. How so?

A. It's sort of an at-a-glance type of tool that gives you a lot of -- a good indication of what you are going to see in the line-by-line prescription data, kind of gives you some risk-type of information right up front, that doesn't require you to do as much -- as much studying of the line-by-line prescription data.

Q. And studying line-by-line prescription data, you mean by prescriber?

A. Yes, by a prescriber or by a pharmacist.

Q. Does NarxCare run reports?

A. NarxCare is simply a software add-on. It's not -- it is not like a different organization.

Q. And manufacturers can't access NarxCare scores of patients, correct?

A. Correct.

Q. Distributors cannot access NarxCare scores of patients?

A. Correct.

Q. Can any requester or an individual with a requester account access the NarxCare score of a patient?

A. Only the healthcare professional roles, so prescribers and pharmacist, and then, as an administrator, I can.

Q. So the, for example, the director of Medicaid cannot access the NarxCare scores of Medicare recipients?

A. Correct.

Q. And can the coroners access NarxCare scores of decedents?

A. No.

Q. What specifically is the NarxCare score designed to achieve?

A. It is a tool that brings attention to various signs of risk, so various behavioral patterns or items that would indicate risk.

It also is a -- it was developed to allow multiple sources of information to be used to basically inform the risk model. To date, it only uses the prescription data from OARRS, but there is the potential to add other information to it in the future, should it be warranted.

Q. Information such as what?

A. Some states are looking at criminal history information, some states are looking at

naloxone distribution or nonfatal overdose type of information. There is a lot of ideas out there right now. I don't believe anybody has actually pulled the trigger on any though.

Q. Is Ohio looking into any of these options?

A. We have discussed them, yes.

Q. How far along are those discussions?

A. I'm not sure, at this point.

Q. Is that a decision that you would make?

A. I would certainly be part of that, but whoever owns the information that we would be adding in would clearly have to be on board as well.

Q. You had mentioned earlier that one of the reports that OARRS was capable of running was the identification of at-risk individuals; do you remember that?

A. We have various queries that look at certain factors of risk, certain risk factors.

Q. And what would you do -- what do you do with information about a patient who is

at risk? For example, when we were talking earlier, it was somebody who might be on multiple drugs that have a dangerous interaction possibility?

A. So there is -- there is limited things we can do currently, but that's one of the things that we have been working on.

So for instance, we do have the project that I mentioned earlier, where we have agents who are doing door-to-door interventions, based off some of this information that we are pulling.

Q. We had also talked -- and I realize I'm skipping around -- about data that when a state or your office started purging files from pre-2014. When did that purge take place?

A. It took place on a regular basis, up to a certain point in time.

Q. When did it start?

A. Well, it would have started probably in 2008, because originally we only kept two years' worth of any type of information.

Q. And it has continued until this latest regulation that requires the five-year

looking-back period?
A. Yes.
Q. So was that around 2014?
A. The statute change was more recent than that. It would have been in 2016.
Q. You mentioned that governor's opioid task force that you are involved in; do you recall that?
A. Yes.
Q. What if any other opioid task forces are you involved in?
A. I'm not.
Q. Is the board of pharmacy involved in any other opioid task forces?
A. I wouldn't know.
Q. The other thing we talked about was grants, that your funding is primarily from grants and federal sources, and then whatever is left over, more or less, is licensing fees; is that right?
A. Correct.
Q. Do you determine the budget for your department on an annual basis?
A. Not entirely. I have -- I certainly have my requests and my ideas of what

I would like to accomplish, but ultimately our director of administration is in charge of the entire agency budget. So it would come down to him and the executive director.

Q. Can OARRS determine how many opioids were lost or stolen or unaccounted for by a particular dispenser?

A. No.

Q. Do you know what a Form 106 is?

A. I've heard of it, not ultimately familiar with it.

Q. You had mentioned that prescribers -- well, let me ask: Are prescribers required to review an outpatient's prescription history, before writing a prescription?

A. Under the circumstances that I mentioned earlier, so prior to writing any opioid or benzodiazepine, with the exception -- with a number of exceptions, and then for other controlled substances, if treatment is going to last more than 12 weeks.

Q. And can OARRS determine if a prescriber has failed to access the database to get that information?

A. Yes, for the most part.
Q. How does it do that?
A. By comparing the prescription data of a prescriber to that prescriber's request information.
Q. And when you say, "Compare the prescription data to the prescriber's request data," the prescription data is what comes from the dispenser, correct?
A. Correct, and the request data would be activity of the -- the activity logs of the prescriber.

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(Thereupon, Deposition Exhibit 13, A PowerPoint Presentation Entitled Two Incentives to Engage Providers: Meaningful Use and Individual Prescriber Reports, Beginning with Bates Label Summit 001285650, was marked for purposes of identification.)

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Q. I hand you what has been marked as Exhibit 13. Exhibit 13 is a PowerPoint presentation entitled Two Incentives to Engage

Providers: Meaningful Use and Individual Prescriber Reports, and it bears production numbers on the bottom right of Summit 001285650 through 5695; do you see that?

A. Yes.

Q. Are you the Chad Garner, MS, who is listed as one of the presenters?

A. Yes.

Q. Do you recall that presentation?

A. Vaguely, it's been a while.

Q. Do you know when it was presented?

A. It has been at least two years ago, I believe. I'm trying to even find my portion of this.

Q. Your portion starts on --

A. There we go.

Q. -- the page ending at 682.

A. Apparently, it was in 2017.

Q. Who was the audience for the presentation that is Exhibit 13?

A. So it was primarily other PMP administrators, but anybody at the Prescription Drug Summit could have attended. So it honestly could have been just about anybody.

Q. If you turn to the page ending 688

of Exhibit 13.

A. Yes.

Q. It says -- actually, let's start with the page before it that ends in 687. It say, "OARRS Practice Insight Report"; do you see that?

A. Yes.

Q. The first sentence, it say, "OARRS Mandator Use Compliance," and it reads, "According to our records, the following patient filled a prescription written by you for a benzodiazepine or an opioid for greater than a seven-day supply. However, an OARRS patient Rx history report was not accessed;" did I read that correctly?

A. Yes.

Q. Is this the type of report we were talking about a minute ago that would be sent to a prescriber when you compare the prescription -- the prescriber data to the prescription report data?

A. Yes.

Q. What is your expectation as to an action by a prescriber upon receiving a report like this?

A. This was actually created in response to -- it was more at the request of the prescriber community. So the list of -- the list of prescribers who failed to check a patient, and as well as who they didn't check with, provided to the appropriate licensing boards, and the prescriber community then, when contacted by their licensing boards, clearly wanted to know who it was that they missed, and so this was the way we responded to that.

Q. And when you say "this," you are talking about the report that is depicted in slide that ends in 5687 of Exhibit 13?

A. Yes. Correct.

Q. Does the licensing board receive a copy of this report?

A. Not this exact report, no.

Q. But it receives some report about compliance by a prescriber?

A. Yes.

Q. How does the report that the licensing board receives differ from what is depicted on the page ending 5687 of Exhibit 13?

A. The report that the licensing board receives covers all of their licensees, rather

than just one.

Q. Does any other entity receive a copy of a report such as that depicted in the page ending 5687?

A. No.

Q. If you turn to the page ending in 5691, it is the slide entitled Appriss Health's PDMP Prescriber Reports. The last entry notes that "Each individualized report is created and electronically delivered to prescribers on a quarterly basis;" did I read that correctly?

A. Yes.

Q. Is that delivered by email?

A. It is.

Q. And that's delivered to an inbox that's associated with the user's account number?

A. Yes.

Q. The next slide is the Appriss -- it has the same title, Appriss Health PDMP Prescriber Reports, and it lists a list of metrics that Appriss provides; do you see that?

A. Yes.

Q. Are those same metrics provided by OARRS?

A. So these have -- we do provide these reports. However, the metrics, I believe, have changed a bit. The report was still in development, at the time of this presentation.

Q. We talked about 24 hour -- the 24-hour reporting cycle for -- I beg your pardon -- for dispensers?

A. Yes.

Q. Does OARRS provide for instantaneous transmission of data?

A. They can, yes.

Q. But it doesn't currently?

A. It does not. We don't require it. The system is capable. That's the purpose, I believe, you pointed out earlier, that we said at least daily, but you can report more often. That would be more often.

Q. All right. And does OARRS provide realtime access to patient reports?

A. Yes.

Q. And based on the NarxCare system, is it true that OARRS now can evaluate patient data and red flag certain patients?

A. It does not red flag certain

patients. It provides risk that is currently determined from the prescription information. There clearly are other factors still that any prescriber or pharmacist needs to consider, besides the information that's on that report.

Q. Do you understand that there are some PDMP systems that have the capability to send a popup alert when the system is accessed for a particular patient?

A. Yes.

Q. Why doesn't Ohio have that?

A. For the reasons that we stated before, because we don't have -- we don't have a patient identifier. We don't have -- we don't always know that the prescriber on the prescription is correct. Many of the states have had those sorts of issues, with those types of systems.

And ultimately, since we require a prescriber to access OARRS prior to prescribing an opioid or a benzodiazepine, there should not be anything that that popup should be telling them that they shouldn't already be seeing.

Q. Does the database have tools that would permit it to classify information it

receives?

A. "Classify"?

Q. For example, could it -- can a database itself -- we talked a little about this -- identify patients at risk?

Could you run a search and ask it to identify patients at risk?

A. We can -- so the database itself -- so the OARRS system, you know, the online, web-based tool does not have anything like that in there.

The database that we run internally, we can run queries to look for certain indications of risk that we know of.

Q. And OARRS can identify top prescribers, correct?

A. Correct.

Q. It can identify top dispensers?

A. Yes.

Q. It can identify top patients?

A. Yes.

Q. OARRS can identify the top areas where opioids are being dispensed, correct?

A. Yes.

Q. And OARRS can identify the top

drugs being dispensed?

A. Yes.

Q. Has the focus of the board of pharmacy changed over time?

A. In what way?

Q. Well, for example, we are talking about opioids right now. Was there a time when meth was the focus?

A. The board of pharmacy is -- only regulates the distribution of legal drugs, so meth would not be within our purview. Since I have been at the board, opioids have been the issue.

Q. What about medical marijuana, is that an issue?

A. Medical marijuana is another program that has been enabled by statute. I don't have a lot of information on that right now.

Q. Does that fall within your purview?

A. No. Only to the extent that the dispensing will eventually by reported to OARRS, but that hasn't started happening yet.

MS. BROWNE: I just need to review notes. I don't know, does anybody else have

questions?

MS. O'GORMAN: Do you want us to start them now?

MS. BROWNE: Is that okay?

THE VIDEOGRAPHER: Could we just take a quick break, because I got to get her a mic.

MS. BROWNE: Yes. Sure.

THE VIDEOGRAPHER: Off the record at 2:42.

(Recess taken.)

THE VIDEOGRAPHER: On the record. 2:43.

EXAMINATION OF CHAD GARNER

BY MS. O'GORMAN:

Q. Good afternoon, Mr. Garner. My name is Debra O'Gorman, and I'm one of the attorneys for Purdue Pharmaceuticals, one of the defendants named in the lawsuits.

Would you please look at Exhibit 9.

A. I got them out of order now. Let's see. There it is. Okay.

Q. Do you recall being asked about the introductory section to this article?

A. Yes.

Q. And I believe that you said you have no firsthand knowledge of much of what was included in the section of the introduction that was read to you; is that correct?

A. Correct.

Q. And is one of the things that you have no firsthand knowledge of the marketing by pharmaceutical companies of --

A. Correct.

Q. Okay. Did you participate in writing this introductory section of the article?

A. The draft of the article was originally -- was written by Dr. Weiner and Dr. Baker, who works with Dr. Weiner, and then the rest of us went through and made our edits and changes as necessary, explained areas that maybe were misunderstood, but I did not actively write that section, no.

Q. Do you recall making any edits or comments on that section?

A. I don't recall, no.

Q. Okay. And you have no medical background; is that correct?

A. That is correct.

Q. Do you have any personal knowledge of marketing practices for opioid drugs in Ohio?

A. No.

Q. Do you have any personal knowledge of aggressive and possibly fraudulent marketing of pharmaceutical drugs -- of opioids in Ohio?

A. No firsthand knowledge, no.

Q. So I take it then you have no knowledge of any specific visits to doctors that you would believe are aggressive or possibly fraudulent, with regard to marketing of opioids?

A. I would have no firsthand knowledge of that, no.

Q. Could you also take a look at Exhibit 11, and that was the PowerPoint presentation.

A. Okay.

Q. Do you recall being asked about the PDR findings --

A. Yes.

Q. -- towards the back of the article?

A. Yes.

Q. And you were asked about overdose

victims that, quote, had a file with OARRS; do you remember that?

A. Yes.

Q. What does "have a file with OARRS" mean?

A. Having not created the slide, I'm assuming a bit here, but my assumption would be that that means that there was no -- if they had a file, that means that there was some record in OARRS, when the patient was requested.

Q. And could that mean just a single reference to a prescription?

A. I would assume so, but I don't know. I didn't -- again, this isn't my presentation.

Q. And you had no involvement in preparing this by Dr. Gilson?

A. No.

Q. Do you know for what period of time he was able to access information in preparing the slide, how far back he was able to go?

A. It would have depended on the patients he was -- the deaths he was investigating. So if he doesn't -- if he

doesn't say, then, no, I don't know.

Q. Does the OARRS system track the history of use of illicit drugs, to your knowledge?

A. It does not.

Q. You were asked earlier in the deposition about access by insurers to the OARRS database, and I think you said that Medicaid insurers and Workers' Comp insurers have access?

A. Correct.

Q. Has any consideration been given to increasing access to any private insurers?

A. We've been -- I believe there is a group looking at it, but it's not something that we have spent much time on, at this point.

Q. And are there any plans for that to happen that you are aware of?

A. Not currently.

MS. O'GORMAN: That's all I have. Thank you.

EXAMINATION OF CHAD GARNER

BY MR. EMCH:

Q. We will run quickly here, so we can try to get done, if that's all right. I think

it is all right with you.

A. Absolutely.

Q. Medicaid and Medicare, we talked about that.

THE NOTARY: Could you introduce yourself, please.

Q. Oh, Al Emch.

My understanding is that those were added as requesters in 2015; does that sound right? You don't have to get it right, but within the past few years they were added?

A. The managed care agencies; is that what you are asking about?

Q. Yes.

A. I believe it has been longer than that. I want to say it was -- I want to say it was closer to four or five years ago.

Q. Do you know why they were added?

A. The legislature added them. I'm sure it was at the request of either the Department of Medicaid or those insurers, but I don't know for sure.

Q. In general, are the requesters -- is it your understanding that the requesters are those who have some level of control or

possible control or insight into potential diversion or misuse or misprescribing?

A. The actual requesters are either the medical director or pharmacy director of those organizations. Those are the only individuals that are permitted access.

Q. But again, is it your understanding that people who are given access normally are those that have some level of possible control in assisting in combatting diversion?

A. Oh, absolutely, yes.

Q. Does OARRS track who pays?

A. Yes.

Q. Does OARRS track whether Medicare or Medicaid or the Worker's Compensation system pays?

A. Yes.

Q. Do you have, as you sit here today, and we can't hold you to any numbers, but do you have any information or comment you can give us about the percentage of opioid prescriptions written and filled in Ohio that are paid for by Medicaid?

A. I don't know.

Q. Do you have any comment about that

at all, is it significant, substantial?

A. I don't know that I have even looked it, to be able to tell.

Q. What about individual insurers, do you have that information, like, oh, just pick one, Medical Mutual, let's say?

A. I do not.

Q. Is that in the OARRS system?

A. It is not.

Q. So Medicare and Medicaid or Worker's Compensation can be tracked or is tracked in the OARRS system, correct?

A. Correct.

Q. Always has been?

A. Yes.

Q. So to the extent that the information is available, one could determine, for any given period of time, how many or what percentage of opioid prescriptions were paid for by those entities?

A. Correct.

Q. Do you know if there has been any decline in those, or anything like that?

A. I don't. I have not looked at it in that manner.

Q. We talked a good bit about suspicious order reports. You know what that is; is that right?

A. I have got a general idea. It is not something I deal with directly.

Q. You indicated, I think, in response to an earlier question that certainly OARRS does not contain or track in any way suspicious order reports?

A. Correct.

Q. I think you said you were not aware of any database, at the board of pharmacy, that tracks or somehow has entered into it or utilizes suspicious order reports?

A. Nothing that I'm aware of.

Q. And if there were one, you would be aware of it, correct?

A. Not necessarily.

Q. There are databases that exist at the board of pharmacy that you don't have any involvement in?

A. Yes.

Q. But then back to the same question, you don't know of any database that tracks or keeps account of, or in any way analyzes

suspicious order reports?

A. None that I'm aware.

Q. Do you have any information about what happens to suspicious order reports?

A. I do not.

Q. There was a time when you indicated that you had provided some data about wholesale distributors' shipments, the data that you get out of the wholesaler portion of OARRS, in connection with a rule or a regulation or statute, I don't remember what --

A. It was a rule.

Q. Is the rule in effect yet?

A. I am not sure about that.

Q. And that is -- there was also some discussion about ARCOS. You know what ARCOS is?

A. Yes.

Q. Would I be correct that, since the beginning in 2006, as far as the data or the specific items that are required to be reported by wholesale distributors, that really it's the same template, it's the same as the ARCOS data that's input, or very close to the same?

A. My understanding is that there are

more classes of drugs that we collect, but the information about each individual sale would be the same.

Q. The template was sort of patterned after ARCOS?

A. Correct.

Q. Do you know of other states that actually have, by the way, that get, essentially, the ARCOS data as well as, of course, the dispensing data for their drug monitoring programs?

A. I'm aware of two.

Q. So Ohio is again out in front on that aspect, right?

A. Correct.

Q. You indicated you started getting that data because you needed -- you wanted to know what was coming in to prescribers who also dispensed, because those prescribers are limited in what they can dispense, right?

A. Correct.

Q. So comparing what's coming in with what's going out gives you a good idea of whether or not they are prescribing more than they are supposed to, on one side, right, more

than their limit?

A. Whether or not they are dispensing more than they should.

Q. Dispensing more than their limit?

A. Yes.

Q. Now, the same can be true with respect to a pharmacy or a dispenser that's tracked in OARRS?

A. To an extent. There is not the hard limit on a pharmacy or other type of dispenser. That is there for a prescriber.

Q. But overall, would you agree that being able to compare what is going into a pharmacy, over a particular period of time, with what is being dispensed by the pharmacy over that same particular period of time, is a very useful piece of information, in trying to cull out or determine possible diversion that is occurring at that pharmacy?

A. Absolutely.

Q. In your experience, would you agree that pharmacies or dispensers don't stockpile controlled substances?

A. I would say that's generally true.

Q. They try to -- they are basically

keeping their dispensing levels commensurate with what their normal need is; they don't have a lot on hand, right?

A. Correct.

Q. So again, knowing what is coming in for a particular period, comparing it with what is going out, and if there is discrepancy between those two, i.e., more coming in then they are dispensing, would be an indicator of potential diversion at the pharmacy?

A. Correct. It would be a possibility.

Q. Have you run that kind of comparison?

A. I have.

Q. Has that been something you have done recently?

A. Yeah.

Q. Have you done that kind of comparison historically? Did you understand my question? Again, since 2011, when distributors were reporting to you the end information for dispensing?

A. So, I mean, we just started getting that information in toward the end of 2011. It

took a while before we really had complete data. We have looked back at that information, from time to time. I don't know how to answer your question further than that.

Q. Routinely, have you looked at that kind of information?

A. It's more of an ad hoc. It's not something that we do on a scheduled basis.

Q. Is that something that you have written a statistical model for or a query, if you will?

A. Yes.

Q. You do have that. How long does it take you to do that analysis?

A. It depends on exactly how I'm looking at it. If I'm looking at a specific drug, it -- you know, and a specific pharmacy, it would only take a few minutes, but if I'm trying to look at something on a more global scale, it can take more than 24 hours.

Q. But again, a specific pharmacy could be done very quickly?

A. Yes.

Q. Has anyone ever asked you, from law enforcement or anyplace else, to do that kind

of analysis?

A. Only from our internal compliance department.

Q. So again, you don't recall ever having such a request from, for example, a sheriff somewhere? We have talked about a sheriff a lot here.

A. There is nothing in statute that would permit them to get that type of information. So I wouldn't be able to provide it, if they did ask. I don't recall whether I have been asked for that before or not.

Q. Is there something in the statute that would prohibit that information?

A. The statute is specifically written such that if it is not permitted, it is prohibited.

Q. Can a sheriff obtain -- as a requester, can a sheriff obtain information about a pharmacy that's under investigation?

A. They can obtain dispensing information. That doesn't happen frequently, but it is possible.

Q. So if the sheriff or somebody in law enforcement were suspicious about a

particular pharmacy on Fifth Avenue, for some reason, and they were investigating that pharmacy, they could go in and look at the dispensing information for that pharmacy?

A. They could. They would have to have an open case for it.

Q. But if that sheriff called you and said, "You know, I'm looking at this dispensing pharmacy, and I have checked, and I've looked at the last three months of their dispensing history, and I would like to know what they purchased during that time," would you be able to give them the purchase information?

A. No. There is knowing in statute that would permit that.

Q. Could you see that that would be a very useful piece of information for law enforcement to have?

A. It could be. Typically, those types of investigators -- or investigations are staff are involved in, but, yes.

Q. The analysis that you did in connection with the change of rule or a new rule with respect to wholesalers --

A. Yes.

Q. -- had you ever done an analysis like that before?
A. Not to that extent, no.
Q. Do you know what a pill mill is?
A. Yes.
Q. Or do you have a definition?
A. I don't know that I've got a clear definition, but I've got the idea.
Q. Which is?
A. It's a place that either lots of pills come from or lots of prescriptions.
Q. Could that be a pain clinic?
A. Typically.
Q. In your experience, are pain clinics regulated in Ohio now?
A. They are.
Q. Since when?
A. Late 2011.
Q. All right. And you do mine the data? You know what you mean by that, by the board of pharmacy mines the data in the OARRS program?
A. That's much of what I would have been describing with the various statistical models and such that we were on, yes.

Q. So the 100 to 500 models are designed to look at the data and try to identify places where there may be a problem?

A. Correct.

Q. For lack of better terminology.

What do you do with the results of that information --

A. I refer --

Q. -- the 100 to 500 models? I'm sorry.

A. I refer to the board's compliance department.

Q. And do you know what they do with it?

A. I do not.

Q. Do you have any information to indicate that they refer the results of those 100 to 500 models that you run to appropriate other agencies?

Obviously the board of pharmacy itself would be one of those, but refer things to the board of medicine, to the board of nursing, to the department of health, to other state agencies that -- and/or to law enforcement?

A. I wouldn't have any -- I don't know the interworkings of that department.

Q. We are running past here.

You indicated, in talking about the diversion at one point during your testimony, that you looked for things that might, sort of, indicate diversion. I think you mentioned doctor shopping and overutilization --

A. Correct.

Q. -- if I remember correctly.

Those would both be identification of patients who might be involved in diversion, right?

A. Correct.

Q. But you also can use it to identify overprescribing --

A. Correct.

Q. -- would that be correct?

A. Correct.

Q. Which would mean a doctor. And would overprescribing include prescribing too many opioids?

A. Yes.

Q. Too much, as far as dosage units are concerned?

A. Yes.

Q. Or for too long a time, too many refills over too long a period?

A. Yes, or any combination thereof.

Q. And with the guidelines that are in place now, since 2012 or 2013, the prescribing guidelines, the limitations in the states, have you seen success in combatting overprescribing?

A. There certainly is -- there are certainly indications that prescribing is coming down. So as I hope, yes. There certainly are still individual cases.

Q. And again, in your reporting, you have seen and have reported significant declines in doctor shopping?

A. Yes.

Q. And the number of prescriptions written?

A. Yes.

Q. And again, obviously, when there are limitations on seven-day or five-day prescriptions as a maximum, those things have all brought down both the number of prescriptions and the amount and number of dosage units and the quantity, in grams, of

opioids that have been placed into the stream in Ohio?

A. Yes.

Q. You think OARRS has been a very effective tool --

A. I do.

Q. -- in achieving that?

A. I do.

Q. Am I correct that the board of pharmacy and OARRS does not track the in and the out, as far as hospitals are concerned?

A. We do track what is sold to a hospital. We do not track what is dispensed in patients. Now, if the hospital has an outpatient pharmacy, then we would receive what comes out of the outpatient pharmacy.

Q. Is there any place within the board of pharmacy or state government, that you know of, that is capable of making some comparison between what, in the way of opioids, came into a hospital and what went -- was either dispensed within the hospital or outside, if you understand my question?

A. I'm not aware of anybody that could do that, no.

Q. Is there a diversion that occurs in hospitals, to your knowledge?
A. I wouldn't know that.
Q. The first that -- were you involved in the development of the prescribing guidelines that have been promulgated in Ohio --
A. I have. I was.
Q. -- you know what I'm talking about?
A. Yes, I was.
Q. Emergency room first, chronic pain, acute pain?
A. I don't believe I was involved in the emergency room, but I was involved with the chronic and acute pain guidelines.
Q. And those guidelines are described as just that, if they are not in a statute?
A. Correct.
Q. Guidelines are just guidelines, right?
A. Correct.
Q. Who makes the decision about what is appropriate to be prescribed to a particular patient?
A. The prescriber.

Q. And am I correct that the prescriber and the pharmacist or the pharmacy are the two places where a prescription can be killed, for lack of a more appropriate term?

A. Yes. I mean, I suppose it could be killed in between by the patient, but, yes.

Q. And the board of pharmacy can't make that decision?

A. Correct.

Q. Nobody else is authorized to make that decision?

A. Correct.

Q. Or let's put it the other way, legally required to make the judgment that the prescription -- the prescription is written and is being dispensed for a legitimate medical purpose, in the usual course of professional practices?

A. As far as I'm aware.

Q. The prescribers and pharmacists?

A. Yes.

MR. EMCH: That's all I have.

MS. BROWNE: Can we take two seconds, please?

THE VIDEOGRAPHER: Off the record

at 3:06.

(Recess taken.)

THE VIDEOGRAPHER: On the record, 3:09.

MS. BROWNE: Defendants have nothing further, Mr. Garner. Thank you very much for your time.

THE WITNESS: Thank you.

THE VIDEOGRAPHER: Off the record. 3:09.

MS. BROWNE: Do you want him to read and sign, get the deposition transcript and review it?

MR. WAKLEY: Send the depo to me, I'll provide it to him. I'm guessing it is going to be too long, but we will look at it, and if we notice anything, we will have him sign off on it.

We will have him sign off on it if it is correct. If we notice anything, we will bring that up at that point.

(Deposition concluded at 3:10 p.m.)

- - - - -

Whereupon, counsel was requested to give instruction regarding the witness's review of the transcript pursuant to the Civil Rules.

SIGNATURE:

Transcript review was requested pursuant to the applicable Rules of Civil Procedure.

TRANSCRIPT DELIVERY:

Counsel was requested to give instruction regarding delivery date of transcript.

REPORTER'S CERTIFICATE

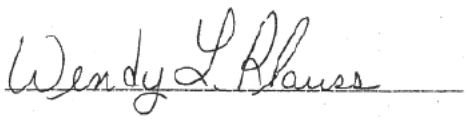
The State of Ohio,)
SS:
County of Cuyahoga.)

I, Wendy L. Klauss, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, CHAD GARNER, was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 19th day of November, 2018.



Wendy L. Klauss, Notary Public
within and for the State of Ohio

My commission expires July 13, 2019.

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

November 19, 2018

To: JAMES T. WAKLEY

Case Name: In Re: National Prescription Opiate Litigation v.

Veritext Reference Number: 3108524

Witness: Chad Garner Deposition Date: 11/14/2018

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3108524
CASE NAME: In Re: National Prescription Opiate Litigation v.
DATE OF DEPOSITION: 11/14/2018
WITNESS' NAME: Chad Garner

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Chad Garner

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3108524
CASE NAME: In Re: National Prescription Opiate Litigation v.
DATE OF DEPOSITION: 11/14/2018
WITNESS' NAME: Chad Garner

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Chad Garner

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 11/14/2018

PAGE/LINE(S) / CHANGE /REASON

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Date Chad Garner

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____

DAY OF _____, 20_____ .

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Notary Public

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Commission Expiration Date

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2016. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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